Calidad en Salud

Better Health for

Women and Children

Quarterly Report

First Quarter, 2004

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Anexos

Acronyms

AA-MC	AIEPI AINM-C, Manejo de Casos
AA-PP	AIEPI AINM-C, Promoción y Prevención
ACCEDA	Atender, Conversar, Comunicar, Encaminar, Describir y Acordar próxima cita
AEC-ONG	Ampliación de la Extensión de Cobertura en Organizaciones No Gubernamentales
AEC-PS	Ampliación de la Extensión de Cobertura en los Puestos de Salud
AIEPI	Atención Integrada a las Enfermedades Prevalentes de la Infancia
AINM-C	Atención Integrada al Niño y la Mujer a Nivel Comunitario
AMMG	Asociación Guatemalteca de Mujeres Médicas
ANDEGUAT	Asociación de Nutricionistas de Guatemala
APROFAM	Asociación Pro-Bienestar de la Familia
AQV	Anticoncepción Quirúrgica Voluntaria
ATR	Asesor Técnico Regional
BRES	Balance, Requisición y Envío de Suministros
CC	Centro Comunitario
CONJUVE	Consejo Nacional de la Juventud
CPT	Contraceptive Procurement Table
CRS	Catholic Relief Services
CS	Calidad en Salud
CTA	Comité Técnico Asesor
CYP	Couple Years Protection
DAS	Dirección de Área de Salud
DHS	Demographic Health Survey
DGRVCS	Dirección General de Regulación, Vigilancia y Control de la Salud
EA	Enfermera Ambulatoria
ENSMI	Encuesta Nacional de Salud Materno Infantil
ETIO	Equipo Técnico de la Investigación Operativa
FA	Facilitador de Área

FC	Facilitador Comunitario
FHI	Family Health International
FI	Facilitador Institucional
FNUAP	Fondo de las Naciones Unidas para la Población
FP	Family Planning
GMP	Growth Monitoring and Promotion
GTI-IEC	Grupo Técnico Interinstitucional de IEC
IEC-BCC	Información, Educación y Comunicación – Behavior Change Communication
IGSS	Instituto Guatemalteco de Seguridad Social
IMCI	Integrated Management Childhood Illness
IPC/C	Interpersonal Communication and Counseling
IUD	Intra-Uterine Device
JHU	Johns Hopkins University
KPC	Knowledge Practices and Coverage
LMIS	Logistics Management Information System
MA	Médico Ambulatorio
MELA	Método Exclusivo Lactancia Amenorrea
MEW	Minimum Expected Weight
MIC	Manejo Integrado de Casos
MOH	Ministry of Health
MSPAS	Ministerio de Salud Pública y Asistencia Social
NGOs	Non-Governmental Organizations
OR-AEC-PS	Operations Research
PAHO	Panamerican Health Organization
PEC-ONG	Ampliación de Extensión de Cobertura en Organizaciones No Gubernamentales
PEVA	Planear, Ejecutar, Verificar y Actuar
PNI	Programa Nacional de Inmunizaciones
PNSR	Programa Nacional de Salud Reproductiva

PNUD	Programad e las Naciones Unidas para el Desarrollo
POA	Programación Operativa Anual
PROEDUSA	Programad e Educación y Saneamiento
PROSAN	Programa de Seguridad Alimentaria y Nutricional
RRHH	Dirección de Recursos Humanos del MSPAS
SAMIG	Sistema Automatizado de Monitoreo Institucional y Gerencial
SDM	Standard Days Method
SIAS	Sistema Integral de Atención en Salud
SIGSA	Sistema de Información Gerencia len Salud
SLAN	Sociedad Latinoamericana de Nutricionistas
SSRA	Strategy on Sexual and Reproductive Health of Adolescents and Youth
SUI	Sistema Unificado de Información
TA	Technical Assistance
TOT	Training of Trainers
TSR	Técnico en Salud Rural
UE	Unidad Ejecutora
UNDP	United Nations Development Programme
UNICEF	Fondo de las Naciones Unidas para la Infancia
UNFPA	United Nations Fund for Population Activities
UPS1	Unidad de Provisión de Servicios I
URC	University Research Corporation
USAID	United States Agency for International Development
USME	Unidad de Supervisión, Monitoreo y Evaluación
UTI	Uterine Tract Infection
VS	Vigilante de Salud

1. EXECUTIVE SUMMARY

1.1. Result 1: Increased Use of Maternal Child Health Services Provided by the MSPAS and Associated NGOs

1.1.1. Family Planning

The following is a summary of monitoring results including couple years protection (CYP) and new acceptors of family planning (FP) methods both nationwide and in the eight priority areas.

CYPs Nationwide and in 8 Priority Areas

Data are included for the months of January (22/26 DAS), February (20/26 DAS); for the month of March data are provided for 12/26 areas nationwide, including 5/8 priority areas. When all data gathering its complete, a 98% achievement of the goal to 2004 first quarter it's expected.

Overall, 21.0% of the target for CYPs in the first quarter of 2004 has been achieved (Table 1) 20.2% for the MSPAS and 23.7% for IGSS. The MSPAS cumulative percentage for CYPs is –4.8 percentage points below the goal, while IGSS is –1.3 percentage points below its goal at 23.7%.

During the first quarter of 2004, the PNSR and *Calidad en Salud* have worked to continue introducing a wide-ranging package of FP services in health centres, posts and hospitals. The increased access to AQV will make certain that those in need of services receive them and that follow-up of treatment is enforced.

Table 1-Number of CYPs Nationwide by Target Achieved, MOH & IGSS, 2004

Nationwide	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
Total	104,698	88,238	84.3	418794	88,238	21.0
MSPAS*	78,891	63,806	80.9	315,566	63,806	20.2
IGSS	25,807	24,432	94.7	103,228	24,432	23.7

* Preliminary data

In the 8 Priority Areas

18.7% of the annual target was achieved by the end of the first quarter (Table 2). CYPs in the 8 priority areas are related to continuous promotion and availability of FP methods in health centres and posts. The number of CYPs for the MSPAS is the result of the acceptance of injectables (72.3 %).

Table 2-Number of CYPs in 8 Priority Areas by Target Achieved, MOH 2004

8 Priority Areas	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
MSPAS	24,530	18,358.0	74.8%	98121	18358.0	18.7%

* Preliminary data (5/8 areas)

The number of CYPs by method for the MSPAS in the 8 priority areas also was measured (Table 3). 72.3% of CYPs came from injectables, followed by a 14.0% in female sterilization. Also a 0.89% came from LAM, SDM and other natural methods, data included by first time in SIGSA. A recent accomplishment to technical assistance from *Calidad en Salud*, driven to improve the information system to collect information about all methods available.

Table 3-Number of CYPs in 8 Priority Areas by Method, MOH, 2004

FP Method	MOH 2004
Depo Provera	13,271
Condom	879
IUD	801
Oral contraceptive	625
AQV male	44
AQV female	2574
LAM	72
SDM	72
Natural Others Methods	20
Total CYPs	18,358

The number of CYPs by method for MSPAS and IGSS nationwide was measured (Table 4). The 48.9% came from injectables, in addition to AQV-female acceptance (30.1%).

Table 4-Number of CYPs by Method, MOH and IGSS, 2004

FP Method	MSPAS 2004	IGSS 2004
Depo Provera	38,525	4,598
Condom	6,060	1,167
IUD	3531	1,757
Norplant	-	154
Oral Contraceptives	3,658	798
AQV-male	385	396
AQV- female	11,264	15,279
LAM	173	45
SDM	190	238
Naturals Others	20	-
Total CYPs	63,806	24,432

New FP Acceptors Nationwide and in the 8 Priority Areas

Data are included for the months of January (22/26), February (20/26); for the month of March data are provided for 12/26 areas nationwide, including 5/8 priority areas.

Nationwide, the goal for new FP acceptors was 20.8 percentage points (Table 5). Some 65.5% of new acceptors prefer Depo Provera nationwide and 73.5% in the eight priority areas. Accumulated data show the MSPAS is at -4.4% of its target while IGSS is at –2.5% of its target.

Table 5-New Family Planning Acceptors Nationwide Provided by the MOH and IGSS, 2004

Nationwide	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
Total	65,622	54624	83.2%	262,489	54624	20.8
MSPAS	57,824	47601	82.3%	231,296	47601	20.6
IGSS	7,798	7,023	90.1%	31,193	7,023	22.5

* Preliminary data

In the 8 priority areas, the MSPAS fails its new acceptor goal by -6.9% (Table 6). The number of new acceptors will continue to increase during 2004 as the new government allows FP services rolled-out and AQV support and hospital services are expanded

Table 6-Number of new acceptors in 8 priority areas by target and achieved, MOH, 2004

8 Priority Areas	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
MSPAS	19697.5	14255.0	72.4%	78790	14255	18.1%

* Preliminary data x/8 areas, March

Table 7-Number of New acceptors by Method, MOH and IGSS, 2004

FP Method	MSPAS 2004	IGSS 2004
Depo Provera	33019	2,786
Condom	4483	1,379
IUD	643	502
Norplant	-	44
Oral Contraceptives	7577	589
AQV-male	35	36
AQV-female	1048	1,389
LAM	691	179
SDM	95	119
Naturals Others	10	-
Total New Users	47,601	7,023

Table 8-Number of New Acceptors by Method, MOH and IGSS Combined, 2004

FP Method	2004
Depo Provera	35,805
Condom	5,862
IUD	1145
Norplant	44
Oral Contraceptives	8166
AQV-male	71
AQV-female	2,437
LAM	870
SDM	214
Naturals Others	10
Total New Users	54,624

1.1.2. AIEPI AINM-C Clinical Institutional Component

District Collaborative Teams

Monitoring of the effect/result indicators of quality care

During the first quarter of 2004, the results of indicators showed improvement. These indicators were stabilized by January when all personnel who had been on vacation returned to the health services.

The indicators include: 1) verification of general danger signs, 2) verification of feeding and nutritional status, 3) adequate classification following evaluation, 4) necessity of vaccination identified and it is administered, and 5) registration sheets complete and adequately filled out. Two significant declines in the tendencies can be noted, at the beginning of October and the end of December, 2003. The first decline probably happened because the team was not as motivated to continue to rigorously measure indicators. The second decline coincides with the year-end vacations of the personnel in the health centers and posts. For the indicator "Children who are prescribed antibiotics but do NOT need them", it was observed that when health staff were on vacation, three percent of children received antibiotics without needing them.

The indicator "Children that are prescribed antibiotics but do NOT receive them" show that 20 percent of children did not receive them which is evidence of the lack of supply of medicines that was observed in the health areas.

In the consolidation session held March 3-4, 2004, several activities were carried out; among them, monitoring the indicators of effect/results, situational room for the presentation of indicators and improvements strategies to maintain the levels reached in the indicators and to document the practices that permitted this to be attained and identification of needs for strengthening the collaborative teams during the follow-up subsequent to the consolidation session.

In the follow-up subsequent to the consolidation session, two visits were made to the collaborative teams, to continue to reinforce the measurement of the indicators, the implementation of improvement cycles (PEVA), the

strengthening the health care processes, the documentation of best practices that would allow the improvements to be maintained, and the use of EXCEL for graphing the indicators.

Collaborative improvement teams for hospital pediatric care

Results

An implementation plan for pediatric care in 13 hospitals in the network of the 8 Areas of the Agreement has been designed for UPSIII.

13 hospitals in the hospital network at the department level have been selected for the implementation of the pediatric hospital care for critical cases using the improvement teams of the collaborative learning model. The hospitals are located in the health areas covered by the Agreement.

The Basic Reference Guide for Hospital Treatment, which includes the standards for quality pediatric care in hospitals at the department level was revised by central level pediatricians and personnel from the Hospitals pediatrics department.

Limitations

Changes in the work chronogram because of the political changes.

Limitation in visits to the districts for lack of approval of the authorities at the central level.

Uncertainties on the part of the members of the collaborative teams in the continuity of the improvement process using this learning model.

1.1.3. Micronutrients

The first quarter of 2004 witnessed the following advancements in micronutrients: the CD "*Mejorando la Salud y Nutrición de la Mujer de Hoy y del Manaña*", which contains presentations delivered the day the three new norms were socialized, was reviewed and reproduced.

Also, work was carried out to define the content and design of a poster on the normative characteristics of micronutrients (in coordination with the IEC component), to be used by all the services as a reminder and guide while attending to different population groups.

Technical assistance was given to PROSAN, in coordination with the monitoring and evaluation component, to institutionalize the procedures for registering information related to micronutrients and exclusive breastfeeding indicators within SIGSA.

1.1.4. AIEPI AINM-C Integrated Case Management (AA-MC)

Due to the limitations caused by the change of authorities in the Ministry of Public Health and Social Assistance (MSPAS), there were few results in the Integrated Case Management component of the AIEPI AINM-C strategy; among them the following can be mentioned:

Technical assistance was given to the staff of the Food and Nutritional Security Program (PROSAN) to strengthen their empowerment of the combined AIEPI AINM-C strategy. It also was provided to help in the preparation of the presentation to be made to the new authorities on the contribution of the health sector to the national policy on food and nutritional security, in which it is the core element.

Calidad en Salud participated in the development and delivery of the presentation for the new authorities of the MSPAS, outlining the cooperation that *Calidad en Salud* and other USAID funded projects have offered to the Ministry of Health.

The process of review, negotiation, and achievement of mutual agreement on the final design of the protocol for Integrated Case Management of the Woman and the Newborn was brought to a conclusion. There was participation in the negotiation process of the instruments for the monitoring and supervision system of the AIEPI AINM-C strategy.

1.1.5. OR on AEC

With respect to the institutionalization of the AEC-PS variant, the local MSPAS authorities in San Marcos have committed themselves to implement the process, to give it continuity, and to take all the necessary steps to assure availability of necessary funds in the future.

Information, coordination and evaluation meetings in the Health Areas and at the central level with UPS I were held.

Provision of basic health services, involving MIC, in 100 % of the community centers in the 3 jurisdictions was achieved.

Systematic implementation, on a monthly basis, of growth monitoring in the 3 jurisdictions was accomplished.

There was a 90% advance in collecting the monitoring and cost information for the final report on the Operations Research (OR) study.

Final line survey for the Operation Research (OR) was concluded.

Final agreement was reached between the MSPAS, *Pro Redes* and *Calidad en Salud* on the indicators to be included in the final OR report.

There are economic constraints on the part of the MSPAS that could affect compliance with the necessary financing for continuing the process with the Extension of Coverage variant, AEC PS.

1.2. Result 2: Improve Household Health Practices

The *Calidad en Salud* IEC/BCC team participated in the development and execution of an advocacy strategy for AIEPI AINM-C. Separate and joint meetings were also held with the Presidential Commissioner to End Hunger, the First Lady and her advisers and the National MSPAS Inter-programmatic Coordinator for Nutrition to present AIEPI AINM-C as the priority community level strategy to prevent malnutrition. A proposal to expand AIEPI AINM-C to the remaining 16 Health Areas was prepared together with PROSAN. The *Calidad en Salud*'s IEC/BCC team also held advocacy/ coordination meetings with the two communication-related units in the MSPAS -the Health Promotion and Education Department (PROEDUSA) and the Social Communication Unit. A proposal to transfer to the former the *Calidad en Salud* IEC/BCC framework, strategies, methodologies, materials (final arts) and instruments was developed and presented to PROEDUSA to be implemented from April to June 2004.

The IEC/BCC team continued to coordinate activities and materials' development with other programs of the MSPAS, namely, with the National Immunization Program (PNI), the National Reproductive Health Program (PNSR), and the Food and Nutrition Security Program (PROSAN), and with the National Technical Coordinator of AIEPI AINM-C. *Calidad en Salud* is presently reprinting 50,000 vaccination brochures and reproducing 500 CDs with vaccination radio spots using project funds, to be distributed in priority municipalities in the week of April 12-16, prior to the vaccination campaign. The GTI-IEC met regularly during the first quarter of 2004, and participated in the follow-up workshop to develop the IEC/BCC strategy on sexual and reproductive health of adolescents and

youth (SSRA). A workshop of IEC Health Area Coordinators (26 social workers) was held on March 4-5, 2004 with technical and financial assistance from *Calidad en Salud*.

Several new FP IEC print materials are in progress (currently undergoing technical revision, pretest or final modifications). Formative research on the Standard Days Method (SDM) User Card conducted through a contract between URC and the Reproductive Health Institute of Georgetown University was completed and the final report presented to Georgetown and URC, and the Health Area and Districts where the research was conducted. As a result of the research, a new version of the SDM User Card was produced.

This quarter the only AIEPI AINM-C material that was not printed last year (the Protocol for the Integrated Case Management of Women) was printed. *Calidad en Salud* provided technical assistance to USAID NGO partners carrying out the strategy (CARE, CRS, HOPE, ProRedes Salud, and Save the Children) to conduct monitoring/ supervisory visits to document the manner in which the strategy has been implemented by different partners. A specific protocol for the visits was prepared by the IEC component and will guide the visits, which will begin on April 19.

Over 6,700 (61 percent) of the vigilantes notebooks were retrieved for analysis. The data in about half of them has been entered and preliminary analysis show that the percentages of children "not growing well" (not gaining minimum weight) by sector, community, jurisdiction and Health Area have decreased. The IEC/BCC follow-up KPC (knowledge, practices and coverage) rural rapid survey was conducted in the last quarter of 2003, two years after the baseline survey was conducted, and data analyses were performed and a final report was written up this quarter. There were some positive findings, especially regarding family planning indicators.

Main results for IGSS during the first quarter of 2004 include printing of AIEPI AINM-C materials adapted for IGSS. The contract with the IEC/BCC team member who provided technical support to the IGSS IEC/BCC strategy will end March 31. Therefore, she spent time documenting IGSS experiences and preparing a list and samples of all of IGSS materials for future reference. The contract of another IEC/BCC team member who was following-up on IEC AIEPI AINM-C materials production and logistics ended December 30. Given the number of requests from NGOs to provide them with IEC background documents, final arts of different IEC print materials, and master radio spots, additional resources will be needed to adequately respond to them.

The major constraint during this quarter was posed by the change in the government because it has involved devoting considerable time to doing advocacy of major project components and orientation about the IEC/BCC support system. In addition, counterpart funds that were to be used in printing/ reprinting IEC materials have been "frozen". In Health Areas, lack of counterpart funds have prevented IEC Coordinators from carrying out monthly meetings with IEC teams and have caused them to cancel IEC activities such as training workshops, supervisory visits and airing of radio spots.

1.3. Result 3: MCH and NGOs are Better Managed

1.3.1. Logistics

During the first quarter of 2004, Calidad en Salud continued to work with the MSPAS and IGSS to work towards improving to the logistics systems.

Despite the delay in activities during the first month of the year due to the changes in new Ministry officials, this has been a very productive quarter for the logistics component during which numerous activities and products were successfully finalized and delivered.

During this quarter, the principal accomplishments were: a) training in logistics management to IGSS personnel, b) training in logistics management and in the use of the computerized module for personnel from Internal Auditing of the MSPAS, c) development of contraceptive procurement guidelines for the IGSS, d) support to SIGSA in presenting the logistics module to new MSPAS personnel and in developing a strategy for implementing the module

in other DAS with the same success experienced in the DAS of Guatemala, e) performing the first national inventory of contraceptives for the MSPAS, f) development of a logistics calendar for the MSPAS, g) development of logistics tools (FOCUS, Tutorial Digital), and h) completion of a curricula for training MSPAS and IGSS personnel in methodologies for forecasting contraceptive and family planning needs.

Because the achievements are numerous and they themselves subdivided into several components, in this report they are organized into six main sections (introduction to new MSPAS officials, training, support to logistics staff, documents, tools, and other).

1.3.2. Monitoring and Evaluation

SAMIG: The transfers of SAMIG to the MSPAS (UPS1-SIGSA) continued with the establishment of a support group, and the revision and updating of the indicators to certify the NGO's contracted by the MSPAS under the extension of coverage process.

UPS1–MSPAS**:** The information systems of the Presidential Commission for the Fight Against Hunger, SIGSA and UPS1 were strengthened through the development and/or restructuring of geo-referenced systems.

Calidad en Salud: The supervision and monitoring system of AIEPI AINM-C was finished, and the process of digitizing the data in the notebooks of the *vigilantes de salud* in the eight priority areas was started.

IO-AEC: The processes for selecting a company to do the final evaluation was supported, and the database for studying costs was finished and implemented.

1.3.3. Planning and Programming

Calidad en Salud continued with the actions, negotiation and advocacy entailed in the design and execution of a Management Capacity Building Plan directed at the technical teams in the Health Areas and districts of the MSPAS.

A matrix was developed to identify challenges by component and program, as well as present and future actors of the MSPAS.

A document was prepared in reply to a request from the Office of International Cooperation of the Ministry for updated information on programs and projects presently being implemented in Guatemala.

A workshop on coordination between the technical personnel of the MSPAS and the project partners of USAID took place.

Calidad en Salud and the *Unidad Ejecutora*, in support of the PNSR, prepared the document on Planning and Programming Guidelines for the year 2004, which could not be implemented due to a decision made by the General Management and the Head of the Normative Technical Programs of the MSPAS.

Objectives of the Planning and Programming

- The preparation of the guidelines for programming activities of the components and the development of the budget, to be put into effect by the Health Areas.
- The preparation, by the DAS, of the plans and programs in accordance with the previously mentioned guidelines.
- The provision of follow-up to the plans and programs carried out at the central level and in the Health Areas, to ensure the institutionalization of the components of the Agreement.

- The strengthening of management capacity of the technical teams in the Area Directorates and the Health Districts.

1.3.4. Supevision – Facilitation

During this quarter, it was not possible to carry out most of the programmed activities due to the change of government and to the appointment of the new chief of the Supervision, Monitoring and Evaluation Unit (USME) of the MSPAS. Those activities carried out were essentially: enter into discussions with the chief of USME to reach agreement on the implementation of the supervision, monitoring and evaluation system; the reproduction and delivery by the *Unidad Ejecutora* of the pending supervision-facilitation instruments and finalizing the development of the guide, indicators, flow of information and the supervision, monitoring and evaluation instruments for the community system.

1.3.5. Finance and Administration

Calidad en Salud, together with the *Unidad Ejecutora*, met several times with the new authorities of the MSPAS in order to present them with the budgetary and financial requirements for the 2004 Agreement counterpart.

During the first quarter of 2004, *Calidad en Salud* and the *Unidad Ejecutora* focused on the continued improvement of the procedures for the procurement of goods and services at both the central and local levels, using the different contracting methods. For this purpose, visits were made to monitor and supervise; technical assistance was given to the technical, administrative and financial staff; tutorials; activities for sharing information, providing orientation, feedback and reinforcement were carried out; and, support was given for the liquidation and request of financial resources.

Internal control processes complemented the activities already mentioned, and consisted of requirements and mechanisms for regulating the execution of counterpart funds.

A workshop on the rules and procedures for managing petty cash, revolving funds and payments through administrative action, was given to the 6 area facilitators of PNSR/UPSII, primary level facilitators, the chief financial officer and monitoring staff hired by the *Unidad Ejecutora.*

Support was given to the development of the 2004 budget for counterpart funds of the *Unidad Ejecutora* and the 8 Health Areas of the Agreement, using UNDP guidelines.

1.4. Result 4: Community Participation and Empowerment

1.4.1. Community Participation Model

During this quarter, mainly coordination and planning activities were implemented with the new authorities of the MSPAS, who were informed of the advances, pending activities and the materials that needed to be developed. Technical and financial support was given to three health areas to reinforce the implementation of the community participation methodology. The community participation manual was modified and then reproduced by an NGO partner of USAID, *Pro Redes Salud*. 1,500 copies of the guide for developing the community situational room were reproduced by the *Unidad Ejecutora* and distributed to the priority health areas of the project.

1.4.2. AIEPI AINM-C Promotion and Prevention (AA-PP)

During the present quarter, it was difficult to implement follow-up activities for the AIEPI AINM-C strategy; however, emphasis was given to advocacy so that activities developed during the implementation of the strategy are adopted and promoted by the new authorities. Despite the difficulties, support was given to the MSPAS in the distribution of IEC materials in the health area of Huehuetenango and of the information system at the community level (*vigilante*'s notebook), in the eight areas of the Agreement.

Also, a workshop was conducted for the central level to discuss implementation of the strategy. Specifically, the workshop was organized to reach agreement on the proposed visits to learn from actual experiences in implementing the strategy. A presentation on the supervision and monitoring system at the community level was also made during the same workshop.

1.5. Result 5: Increased Use of MCH Services by IGSS

The plans for 2004 are directed toward the institutionalization of the joint processes that will allow the IGSS to produce its own IEC materials, and improve its logistics, supervision and information systems, which will result in an improved management of its maternal child programs and better use of quality services for women and children.

The provision of family planning services received a hard blow when the Medical Deputy Manager took the provisional decision, in November 2003, to limit the delivery of contraceptive methods in all its health care units, exclusively to 45 days after birth, not only to the affiliates (woman who works and pays quotas to the IGSS) but also the beneficiaries (wife or cohabitant of the worker).

This temporary decision will only be effective while they carry out the internal studies in the Institute to demonstrate the benefits, both from the point of view of health as well as cost effectiveness, of family planning. The results would then be presented to the Governing Board for official status to be given to the program, and for the timeframes for the eligibility of the users of these services to be defined.

It is important to mention that all the necessary technical assistance, policy advocacy and scientific evidence has been provided to the commission responsible for the report, to make sure that the unrestricted right to family planning services is fully justified and hopefully approved, which would be an important success and a demonstration by the IGSS of a greater commitment in benefit of the health of Guatemalan women.

On the other hand, an excellent result was obtained: the Strategy for the Integrated Management of Childhood Illness (IMCI) was given official status in the Institute as an health care norm, by means of Management Agreement No. 001/2004, dated January 9, 2004.

Key IGSS results:

- The Strategy for the Integrated Management of Childhood Illness (IMCI) was approved as the Institutional health care norm by means of a Management Agreement.
- The application of the AIEPI AINM-C strategy was implemented at the community health care level (level I) in the Escuintla and Suchitepéquez departments, during which 377 members of the basic health care teams at the community level in the same departments were trained, and 117 members of personnel at levels II and III were inducted.
- The design, validation, reproduction and distribution of the IEC materials for the AIEPI AINM-C strategy were put into effect.

- In-service training on IMCI was given to the pediatric care unit in Villa Nueva (a municipality in the department of Guatemala) and, as a result, authorities and service providers, approved the creation and development of this unit as a model and training center for the IMCI strategy.

- The personnel in the Medical Audit, Supervision and Control Department were trained in the use, knowledge and application of the manuals for the logistical management of the contraceptives.

- Technical assistance was continued to the training centers for family planning and IMCI, to the Medical Audit, Supervision and Control Department in supervision-facilitation, and to the Directorate of Strategic Planning for the development of a proposal for an information system adequate for the needs and resources of the Institute.

2. MSPAS RESULTS

2.1. Result 1: Increase in the Use of Mother and Child Health Services provided by the MSPAS and its Partner NGOs

- Community Health Agents Provide Quality Care
- Health Facilities Provide Quality Maternal Child Health Services
- Innovative Approaches for Improving the Quality and Coverage of Maternal Child Health Services are Adopted

2.1.1. Family Planning Results

The following is a summary of monitoring results including couple years protection (CYP) and new acceptors of family planning (FP) methods both nationwide and in the eight priority areas.

CYPs Nationwide and in 8 Priority Areas

Data are included for the months of January (22/26 DAS), February (20/26 DAS); for the month of March data are provided for 12/26 areas nationwide, including 3/8 priority areas. As the new SIGSA application will be installed at national level we expect this trouble it's solve.

Both 2002 and 2003 first quarter report with whole data available reached 98% of the first quarter goal. It means that if we count with all the information for 2004 first quarter, the goal achieved will be approximately 98% of the goal expected to 2004 first quarter. Also, data available fall short to see information from San Marcos health area responsible from 7.2% to the national CYPs production; Guatemala health area was not reporting AQV production to all months from 2004. Guatemala health area provides 17% of national production. Instead Calidad en Salud already have not operative personnel at local level the FP national program have created a FP services need which is evolving to a critical mass population demanding contraceptives. According to 2002 DHS data, contraceptive prevalence rate it's around 43% significant 1.2 million women in reproductive age demanding FP.

Overall, 21.0% of the target for CYPs in the first quarter of 2004 has been achieved (Table 9) 20.2% for the MSPAS and 23.7% for IGSS. The MSPAS cumulative percentage for CYPs is –4.8 percentage points below the goal, while IGSS is –1.3 percentage points below its goal at 23.7%.

During the first quarter of 2004, the PNSR and *Calidad en Salud* have worked to continue introducing a wide-ranging package of FP services in health centres, posts and hospitals. The increased access to AQV will make certain that those in need of services receive them and that follow-up of treatment is enforced.

Table 9-Number of CYPs Nationwide by Target Achieved, MOH and IGSS, First Quarter 2004

Nationwide	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
Total	104,698	88,238	84.3	418794	88,238	21.0
MSPAS*	78,891	63,806	80.9	315,566	63,806	20.2
IGSS	25,807	24,432	94.7	103,228	24,432	23.7

In the 8 Priority Areas

18.7% of the annual target was achieved by the end of the first quarter (Table 10). CYPs in the 8 priority areas are related to more promotion and availability of FP methods in health centres and posts. The number of CYPs for the MSPAS is the result of the acceptance of injectables (72.3 %).

Table 10-Number of CYPs in 8 Priority Areas by Target Achieved, MOH, 2004

8 Priority Areas	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
MSPAS	24,530	18,358.0	74.8%	98121	18358.0	18.7%

The number of CYPs by method for the MSPAS in the 8 priority areas also was measured (Table 14). 72.3% of CYPs came from injectables, followed by a 14.0% in female sterilization. Also a 0.89% came from LAM, SDM and other natural methods, data included by first time in SIGSA.

Table 11-Number of CYPs in 8 Priority Areas by Method, MSPAS, 2004

FP Method	MSPAS 2004
Depo Provera	13,271
Condom	879
IUD	801
Oral Contraceptives	625
AQV-male	44
AQV-female	2,574
LAM	72
SDM	72
Naturals others methods	20
Total CYPs	18,358

The number of CYPs by method for MSPAS and IGSS nationwide was measured (Table 12). The 48.9% came from injectables, in addition to AQV-female acceptance (30.1%).

Table 12-Number of CYPs by Method , MOH and IGSS, 2004

FP Method	MSPAS 2004	IGSS 2004
Depo Provera	38,525	4,598
Condom	6,060	1,167
IUD	3,531	1,757
Norplant	-	154
Oral Contraceptives	3,658	798
AQV-male	385	396
AQV- female	11,264	15,279
LAM	173	45
SDM	190	238
Naturals Others	20	-
Total CYPs	63,806	24,432

New FP Acceptors Nationwide and in the 8 Priority Areas

Data are included for the months of January (22/26), February (20/26); for the month of March data are provided for 12/26 areas nationwide, including 5/8 priority areas.

Nationwide, the goal for new FP acceptors was 20.8 percentage points (Table 13). Some 65.5% of new acceptors prefer *Depo Provera* nationwide and 73.5% in the eight priority areas. Accumulated data show the MSPAS is at -4.4% of its target while IGSS is at –2.5% of its target.

Table 13-New FP acceptors nationwide provided by the MOH and IGSS, 2004

Institution	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
Total	65,622	54,624	83.2%	262,489	54,624	20.8%
MSPAS	57,824	47,601	82.3%	231,296	47,601	20.6%
IGSS	7,798	7,023	90.1%	31,193	7,023	22.5%

In the 8 priority areas, the MSPAS fails its new acceptor goal by -6.9% (Table 14). The number of new acceptors will continue to increase during 2004 as the new government allows FP services rolled-out and AQV support and hospital services are expanded.

Table 14- Number of new acceptors in 8 priority areas by target and achieved, MOH, 2003

8 Priority Areas	First Quarter			Total		
	Target	Achieved	%	Target	Achieved	%
MSPAS	19697.5	14255.0	72.4%	78790	14255	18.1%

The number of new FP acceptors by method for the MSPAS and IGSS was measured (Table 15 & 16).Both tables show the amount of new acceptors by institution and by method, specifically, Depo Provera in MSPAS with 69.4% and IGSS with 39.7%.

Table 15-Number of new acceptors by method, MOH and IGSS, 2004

FP Method	MSPAS 2004	IGSS 2004
Depo Provera	33019	2,786
Condom	4483	1,379
IUD	643	502
Norplant	-	44
Oral Contraceptives	7577	589
AQV-male	35	36
AQV-female	1048	1,389
LAM	691	179
SDM	95	119
Naturals Others	10	-
Total New Users	47601	7,023

Table 16-Number of new acceptors by method, MOH and IGSS combined, 2004

FP Method	2004
Depo Provera	35,805
Condom	5,862
IUD	1145
Norplant	44
Oral Contraceptives	8166
AQV-male	71
AQV-female	2,437
LAM	870
SDM	214
Naturals Others	10
Total New Users	54,624

In the first quarter of 2004 little progress was made in FP, especially with respect to the organization of the FP service provision by the new ministry of health authorities. Despite the delay in activities, *Calidad en Salud* continues providing surgical equipment to health centres and posts, particularly for IUDs. In hospitals, the provision of surgical equipment for AQV procedures continues and has coincided with some follow up to service delivery, in turn improving the provision of services. The capacity for collection, management, analysis and decision-making based on information related to FP also has improved through the technical assistance provided before to the service units at the local level of the MSPAS. Additionally, the logistics component achieved improvements in the supply of contraceptives. This achievement has facilitated the measurement of demand for contraceptive methods throughout the service system.

Organization of Reproductive Health and Family Planning

During the first quarter of 2004, the recently appointed Director of the PNSR was in the process of establishing the PNSR goals for the year. These goals will be established based on the results of data collected in 2003 including the data on population of reproductive age and data on access to FP providers. Calidad en Salud will support to convey these goals in order to continue improving FP services and use the information to make decisions.

The availability of AQV services was strengthened during this quarter. *Calidad en Salud* developed a national AQV family planning program concept paper, a handbook for service providers and a new set of norms aimed at standardizing the performance of the MOH personnel involved in FP services including admission, documentation and support processes for all the potential clients to the FP program. The strategies are intended to improve workforce performance, update norms , and increase access through an improved scheme of referrals from community-level facilities to hospitals.

Ongoing TA to the PNSR

Calidad en Salud FP staff continued to provide organizational and management assistance related to planning the FP client centred program for the year that includes: management based on accurate information, team building and updating referral system, promotional strategies and also methodology transference and needed supplies projections.

Training

No personnel were trained during this quarter due to an administrative order from new government autorithies. During this year our efforts will focus on follow up with trained providers who apply methodologies developed to make FP program sustainable.

Norms and guidelines

During March, *Calidad en Salud* provided technical assistance to come to an agreement on the set of guidelines to regulate Family Planning Service provision. These guidelines were revised by a technical committee and are in the process of being approved by the decision-making personnel from the MOH and PNSR new authorities.

Teenager's Clinic at *San Juan de Dios* Hospital

Calidad en Salud provided technical assistance and support to maintain a functioning teenager's clinic at *San Juan de Dios Hospital*. The clinic provides FP services for teenagers age 10 – 19 and is run by a multidisciplinary staff. 723 patients attended the clinic during the first quarter. The most commonly attended health problems included: responsible parenthood, FP, growth monitoring, vulvovaginitis, psychological orientation, and dismenorrea. *Calidad en Salud*, in coordination with PNSR, is developing a set of norms to provide FP methods at the clinic. During the next quarter *Calidad en Salud* will help to provide necessary furniture for a training centre that will provide instruction to hospitals across the country in order to convey differentiated methodologies to deal with teenager's problem.

Equipment for FP during 2004, First Quarters

Calidad en Salud provided 34 IUD insertion kits, 34 Emergency Boxes, 20 Minilap kits, 12 complete sets for FP clinics and 7 "*aspiradores de flemas" to* MOH hospitals, see Annex F. These donations were made in order to meet increased demand for FP services created by IEC activities and by the training of health personnel in FP promotion.

Limitations

- The FP Program in the MSPAS needs to be strengthened in order to promote institutionalization of FP activities. At present, most of the FP technical activities rely on unstable personnel.
- The new authorities of the MOH are recently assuming their position; it could be a problem to provide technical support at the local level in order to attend to an increasing demand for FP services.
- Although substantial improvements are being made in the logistics system, low stocks of contraceptives at service facilities continue to be a barrier to the expansion of FP to new users (particularly for Copper T).
- The MSPAS information system continues to be an obstacle for decision-making, as information data arrive late and are often incomplete.

2.1.2. Child Health (Clinical IMCI) Results

Introduction

In the first quarter of 2004, implementation of the clinical institutional component of the AIEPI AINM-C strategy focused on strengthening the strategy at levels II and III of the health care system. Several activities were carried out at the second level: a) the follow-up to the 17 districts with teams to improve the collaborative learning model, prior to the consolidation session; b) the consolidation session with the collaborative teams; and c) the preparation of the guidelines for documenting the best practices resulting from the consolidation session, and for the expansion of the improvements to the health posts, other components and other districts. At the third level, the processes to improve the quality of care for children under five who enter the hospitals in severe condition commenced in 13 hospitals. Additionally, the central level team was organized, a meeting of experts was held to define the processes and indicators to be improved and the guidelines for adapting the "Basic reference guide for hospital treatment" were developed. Subsequent to these activities will be to determine the baseline for pediatric hospital treatment, the improvement plan, the training in pediatric care, and the continual improvement of quality using the collaborative teams in the hospitals.

2.1.2.1. Collaborative Teams

Monitoring of the effect/result indicators of quality care

In the following graphs presented are the values of the eight effect/result indicators for children from 2 months to less than 5 years, which were measured by the districts collaborative teams to show the progress resulting from the implementation.

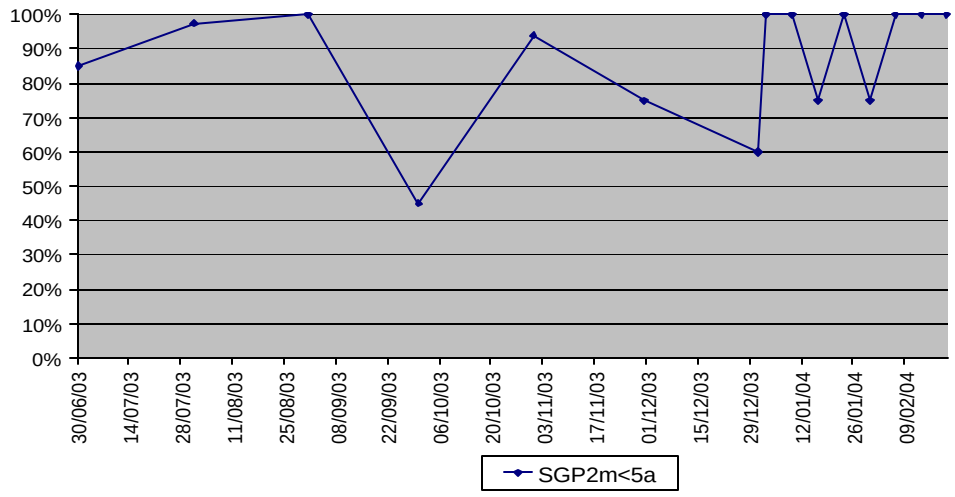
Although the indicators are measured on a weekly basis by the district collaborative teams, the period from June to December of 2003 is resulted on a monthly basis. If the graphs were presented on the basis of the weekly presentation it would become overloaded, and would not permit an adequate visualization of the data; as of January 2004, the data is presented on a weekly basis.

In the following five indicators: 1) verification of general danger signs (SGP), 2) verification of feeding and nutritional status, 3) adequate classification according to the evaluation, 4) necessity of vaccination identified and it

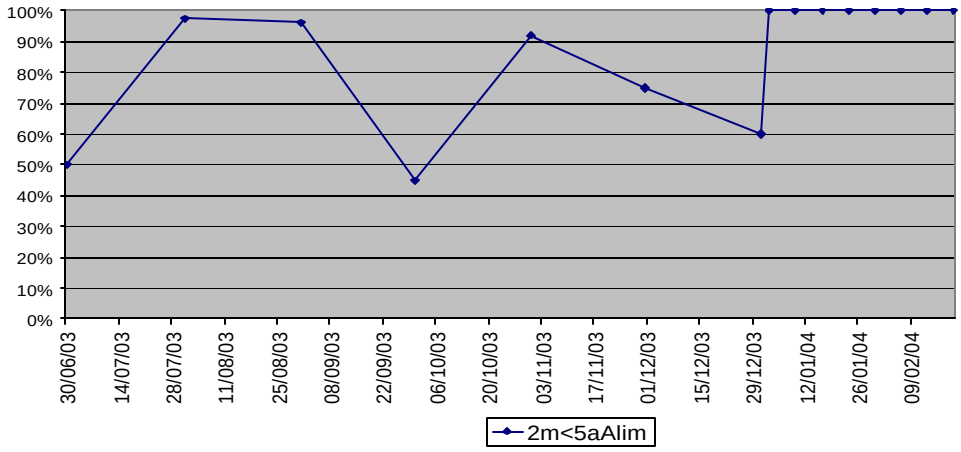
is administered, 5) registration sheets complete and adequately filled, two significant declines in the tendencies can be noted, at the beginning of October and the end of December. The first decline coincides with the second action period, which was extended longer than expected because the initial date for learning session 3 was postponed, and the team lost their motivation to continue the rigorous measurement of the indicators. The second decline coincides with the year-end vacations of the personnel in the health centers and posts, and due to the reduction in staff and increase in the workload, the registration sheets were not filled out as carefully as in more regular periods.

The improvement in the tendency of the indicators is observed again in January, which coincided with the return of the personnel from vacation and the follow-up on by the facilitation team from the central level; it is from that point that the increase and steadiness of the values of the indicators can be observed.

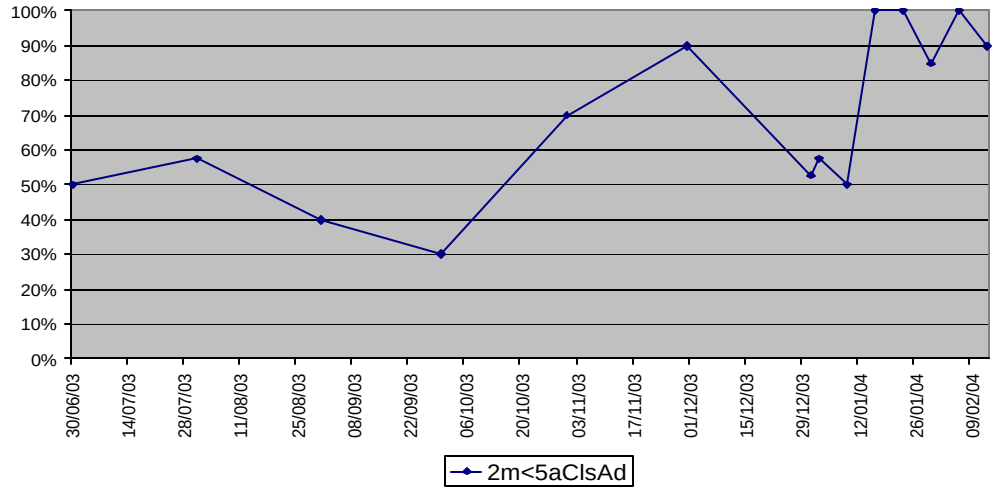
Graph 1- Verification of General Danger Signs (SGP) in children from 2 months to 5 years old



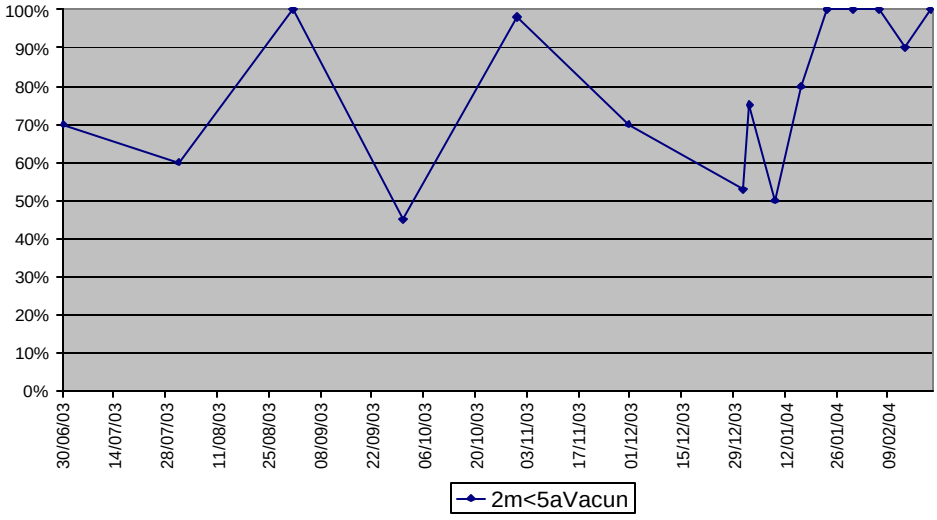
Graph 2 - Verification of feeding and nutrition status in children from 2 months to 5 years old



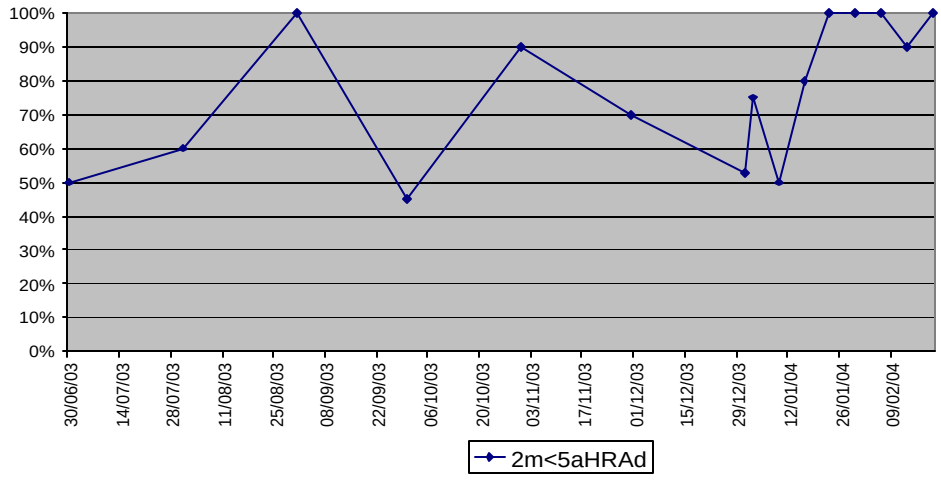
Graph 3- Adequate classification in children from 2 months to 5 years old



Graph 4- Necessity of vaccination in children from 2 months to 5 years old



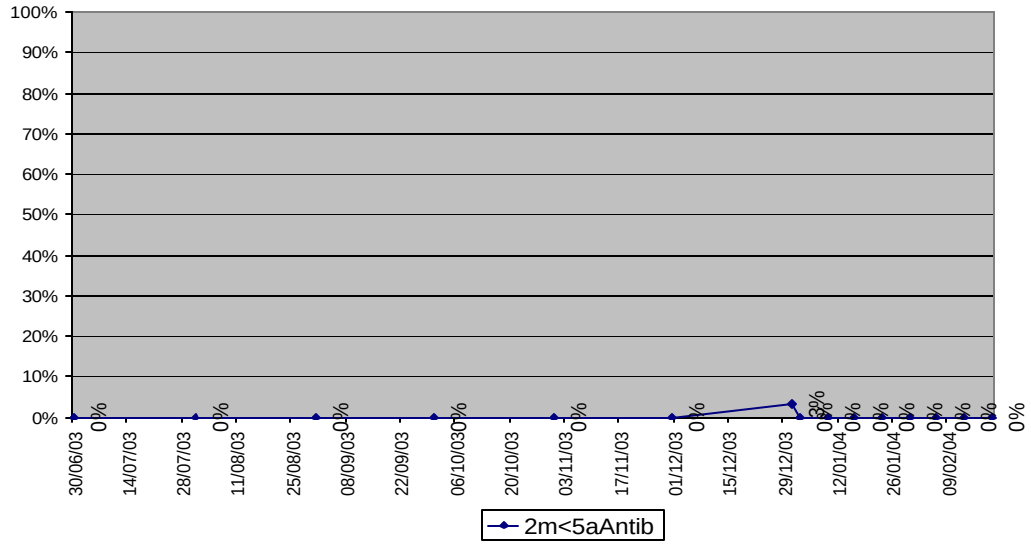
Graph 5- Registration sheets complete and adequately filled out in children from 2 months to 5 years old



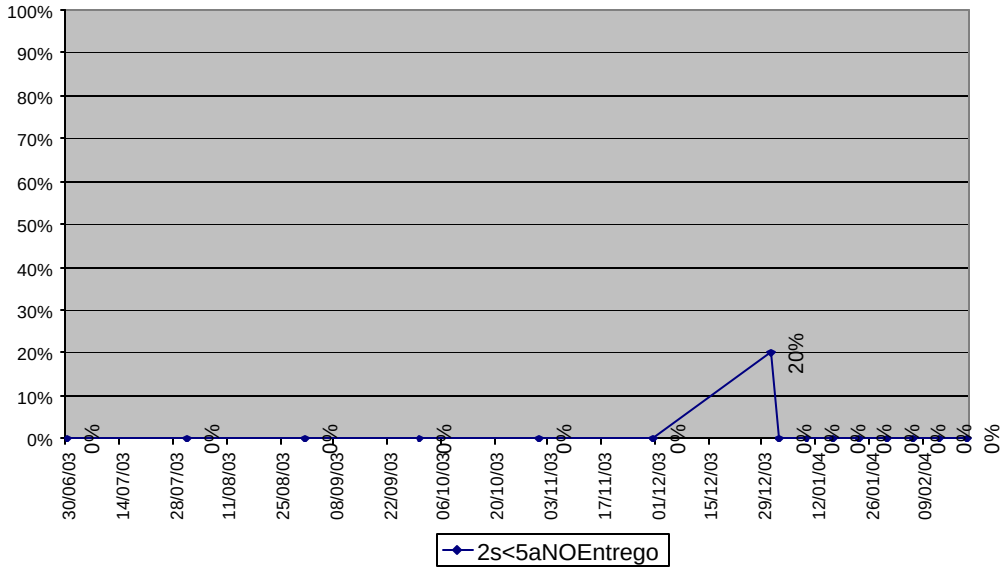
With respect to the indicator 'Children who are prescribed antibiotics but do NOT need them', it can be observed that when the health staff are on vacation, three percent of the children receive antibiotics without needing them probably due to an error of someone on the team and the absence of the other members of the team; the indicator returns to zero percent when the service is stabilized, with the return of the staff that were on vacation.

The indicator 'Children that are prescribed antibiotics but do NOT receive them' shows that at the end of the year 20 percent of the children did not receive them, which is evidence of the lack of supply of medicines that was observed in the health areas during this period.

Graph 6- Antibiotic prescribed NOT necessary in children from 2 months to 5 years old who are prescribed antibiotics but do not need them



Graph 7- Antibiotic NO delivered in children from 2 months to 5 years old that are prescribed antibiotics but do not receive them



Consolidation session on the initial phase of the model: the learning process of the collaborative teams

In the consolidation session held on March 3 and 4, 2004, the following activities were carried out: 1) monitoring the indicators of effect/results, 2) situational room for the presentation of the indicators and of the improvements suggested for enhancing each indicator, 3) a plenary session for setting forth what had been identified in each district as repeated practices that permitted the maintenance of the level reached in each indicator, 4) strengthening in quality themes related to the cycles of rapid improvement (PEVA), 5) strategies to maintain the levels reached in the indicators and to document the practices that permitted this to be attained, 6) indispensable requisites for continuing the expansion to other components – for example: logistics and family planning -- in the same district, to its health posts and support for the expansion to other district, and 7) identification of needs for strengthening the collaborative teams during the follow-up subsequent to the consolidation session.

As a result of the monitoring, irregularities were identified in indicator tendencies, showing abrupt changes that went from improvement to absolute deterioration; these changes coincided with the staff going on vacation at the end of the year, which generated little or no application of the cycle of rapid improvement (PEVA) on the part of the collaborative teams.

In the plenary session, the districts analyzed the information of the others in the situational room and laid out a series of activities that, in their opinion, would permit improvements in the tendency of the indicators; it was not possible to exactly identify the practices that the collaborative teams have developed to maintain the optimum level of the indicators during at least 8 weeks. It was concluded that the collaborative teams have not identified nor documented the best practices, for which technical assistance will be given to do so in the next quarter.

Due to the weakness encountered in the documentation of the best practices, it was decided that the subject of expanding to other components in the district, to its health posts and to other districts, should not be carried out until the teams have strengthened their internal processes.

Follow-up to the collaborative improvement teams subsequent to the consolidation session

In the follow-up subsequent to the consolidation session, two visits were made to the collaborative teams, to continue reinforcing them in the measurement of the indicators, in carrying out the improvement cycles (PEVA), in strengthening the attention processes, in the documentation of best practices that would allow the improvements to be maintained, and in the use of EXCEL for graphing the indicators.

Advances in the implementation of the collaborative teams at a moment of political change

In this first quarter of 2004, a new government administration took possession. In spite of the continuance of the support activities to the collaborative teams, this moment has influenced the performance of these teams, due to uncertainty as to whether the new government will support the actions already programmed during the preceding administration.

In order to minimize as much as possible the de-motivation or uncertainty of the improvement teams, the visits to the districts have continued, with the endorsement of the new authorities at the central level, who have been informed about the model, the advances, the achievements, the limitations and the necessities for keeping the process alive.

An opportunity was found to take central level authorities of UPSII on a visit to the districts applying IMCI and that do, or do not, have collaborative teams. The authorities were able to identify that where collaborative teams have been formed, it was possible to better monitor the implementation, apart from the fact that the teams themselves assumed responsibility for their improvements.

There is, at this moment, a positive attitude on the part of the new authorities toward the IMCI strategy and of the importance of the collaborative teams for the implementation of IMCI at level II. Subsequent to the visit to the districts, the authorities have felt motivated to promote at the highest political levels the benefits of the IMCI strategy and the incorporation of innovative actions to improve the implementation.

2.1.2.2. Collaborative improvement teams for hospital pediatric care

Introduction

With the facilitation of *Calidad en Salud*, the *Unidad de Provisión de Servicios III* is leading the process, with a high degree of empowerment such that, in spite of the political moment, the change of authorities and changes to the work chronogram, the processes continue forward.

The activities programmed for this quarter have been carried out just as planned: a) modification of the implementation plan, b) organization of the teams at the central and department level, c) meeting of the experts to define for the central level the processes and indicators to be improved in the hospitals, d) coordination with PAHO for the endorsement and adaptation of the Basic Reference Guide for hospital treatment, and e) workshop on the guidelines for the revision of the Basic Reference Guide, which was handed to the pediatricians at the central level and in the hospitals in the departments, for its review and subsequent editing.

Results

An implementation plan for pediatric care in 13 hospitals in the network of the 8 Areas of the Agreement has been designed for UPSIII, through the teams for improving the collaborative learning model.

There are three processes and 30 general indicators of improvement; the three processes and the indicators being proposed are related to the improvement of inputs, equipment and procedure handbooks, quality care on the part of the providers and the processes of referral and reply to the level from where the referral originates.

13 hospitals in the hospital network at the department level have been selected for the implementation of the pediatric hospital care for critical cases using the improvement teams of the collaborative learning model. The hospitals are located in the health areas covered by the Agreement.

The revision of the Basic Reference Guide for Hospital Treatment, which includes the standards for quality pediatric care in hospitals at the department level.

The integration, between the performance quality teams of CALIRED and the collaborative teams formed for pediatric care, of the efforts to improve the quality of care at the hospital level has been coordinated with JHPIEGO.

The implementation of IMCI through the improvement teams of the collaborative learning model has developed in a positive manner, and counts with total empowerment on the part of the UPSIII, who is leading the process positively, with the support of *Calidad en Salud*.

Limitations

Changes in the work chronogram because of the political changes. Limitation in visits to the districts for lack of approval of the authorities at the central level.

Uncertainty on the part of the members of the collaborative teams in the continuity of the improvement process utilizing this learning model.

2.1.3. AIEPI AINM-C Case Management (AA-MC) Results

Introduction

The results obtained by the Integrated Case Management component of the AIEPI AINM-C strategy during the first quarter of 2004 were limited. Special circumstances affecting all activities of *Calidad en Salud* were caused by a change of authorities in the Ministry of Public Health and Social Assistance. Results that were achieved occurred mainly at the central level and included: 1) the finalization of the process of review, negotiation, and achievement of mutual agreement on the final design of the protocol for Integrated Case Management of the Woman and the Newborn, and approval for its printing was obtained from the normative technical coordinator of the strategy in the MSPAS; 2) technical assistance was given to PROSAN to strengthen their empowerment of the AIEPI AINM-C strategy, and in the preparation of the presentation to be made by this program to the new authorities on the contribution of the health sector to the national policy on food and nutritional security; 3) participation in the elaboration and delivery of the presentation to the new authorities on the cooperation that USAID projects have given to the Ministry of Public Health and Social Assistance; 4) participation in the process of review and negotiation of the monitoring and supervision instruments for the AIEPI AINM-C strategy at the community level; 5) continued participation in meetings of the AIEPI AINM-C team for follow-up to the strategy; and, 6) participation in the review of the results of the community participation component.

Institutionalization

During the first quarter of this year, the process of institutionalization of the integrated case management component was strengthened in the following aspects: a) active participation in the processes developed by the AIEPI AINM-C team to obtain the acceptance of the strategy by the new authorities in the Ministry of Health; b) technical assistance to PROSAN to strengthen its empowerment of the AIEPI AINM-C strategy, and in preparation of the presentation to be made by this program to the new authorities on the contribution of the health sector to the national policy on food and nutritional security, during which the program presented the AIEPI AINM-C strategy as the proposal to be implemented; and, c) participation in the development and delivery of the presentation to the new authorities on the cooperation that *Calidad en Salud* and other USAID projects have provided to the Ministry of Public Health and Social Assistance.

Planning and Coordination

During the first quarter of 2004, activities related to coordination and planning involved participation in: a) meetings of the AIEPI AINM-C strategy team at the central level, to standardize the follow-up process to implement and expand the strategy to other health areas; b) coordination with the NGO partners of USAID for programming the visits to the local level, where different aspects of the AIEPI AINM-C strategy were being applied; c) the national technical group, coordinated by PROSAN and SEGEPLAN, that is developing the proposal for the Policy on Food and Nutritional Security that was presented to the new authorities; d) meeting with PROREDES, where the distinct degrees of cooperation of each of the projects were established for the design and implementation of the strategy; and, e) the development of the matrix of advances and pending commitments under the strategy, which was presented to the new authorities.

Materials

During the first quarter of the year, activities were carried out related to different materials of the component, the most important being: a) finishing the Protocol for Integrated Case Management of the Woman and the Newborn, and authorization for its reproduction; and, b) participation in the review of the AIEPI Basic Reference Guide for Hospital Treatment.

Supervision, Monitoring and Evaluation

During this quarter, there was participation in the team work process of the AIEPI AINM-C group that is reviewing and finalizing the instruments and processes related to supervision-facilitation of the two components of the AIEPI AINM-C strategy. The necessary modifications were made to the supervision instruments for integrated case management.

Limitations

Due to the change of authorities and the instructions received to not carry out any activities in the DAS, all the processes to provide tutorials and follow-up to integrated case management ceased, and there were no advancements in anything that was programmed at the DAS level for the first quarter.

The prolonged process for developing and reviewing the MIC materials has resulted in a delay in reproducing them; as a consequence, the reproduction of the register sheets that was the responsibility of the *Unidad Ejecutora* was held up.

It has not been possible to obtain current data on the performance of the MIC providers because the DAS and NGO teams have not used the instrument to evaluate providers performance in a systematic manner.

The difficulties and non-compliance on the part of the MSPAS in processing the disbursements to the NGO Administrators and Providers of Health Services, has been one of the fundamental factors in delaying the provision of services required to implement integrated case management, especially in the purchase of basic medicines.

During this quarter, it has not been possible to work with the counterparts in UPS1 of integrated case management as they have been occupied with reviewing the agreements with the NGO Administrators and Providers of Health Services.

2.1.4. Micronutrients Results

Introduction

During the first quarter of 2004, there was minimal advancement in the promotion of micronutrients due to the change in authorities in the Ministry of Public Health and Social Assistance (MSPAS). Technical assistance was

mainly focused on strengthening the capacity of technical personnel in the Food and Nutritional Security Program (PROSAN), responsible for the micronutrient norms in the MSPAS. The work products related to micronutrients during the first quarter included: 1) strengthening the technical capacity of PROSAN staff in the review of the registers kept during 2003 by SIGSA for supplementation of iron, folic acid, vitamin A, and exclusive breastfeeding up to sixth months, in coordination with the monitoring and evaluation component: 2) coordinating with PROSAN to develop the content and diagrams for a poster on the normative aspects of iron, folic acid, vitamin A and iodine, in coordination with the IEC component; and, 3) delivering 35 copies of the CD "*Mejorando la Salud y Nutrición de la Mujer de Hoy y del Manaña*." to PROSAN.

Coordination and Planning

During the current quarter, coordination with PROSAN was strengthened. The following products are a result of this coordination: 1) motivating, negotiating with and convincing the program's technical staff of the need to present the AIEPI AINM-C strategy (including micronutrient supplementation and the promotion of exclusive breastfeeding) as a way for the health sector to contribute to the national policy on food security; 2) supporting the systematic offering of micronutrient supplementation to all children under two, and to women of reproductive age, in the municipalities at risk of neonatal tetanus, during the Vaccination Week of the Americas; and, 3) participating in the review of results from the community participation component, during which it was agreed to include data on micronutrient supplementation in the proposed situational room notebook for the community centers.

Materials

The following results were obtained with relation to materials in the micronutrient component during this quarter: a) design of an integrated poster for the normative aspects of micronutrients (iron, folic acid, vitamin A and iodine), in coordination with the technical staff of PROSAN and the IEC component. At this moment, the drawings are being developed and the changes resulting from the validations carried out by IEC advisors are being made; b) 35 copies of the CD "*Mejorando la Salud y Nutrición de la Mujer de Hoy y del Manaña*" were reproduced and delivered to PROSAN. The CD's will be distributed to the 26 DAS in the country and to the new authorities; and, c) support was given to the community participation component to pre-design the role of micronutrient supplementation in the situational room.

Supervision, Monitoring and Evaluation

In coordination with the monitoring and evaluation component, information was obtained from SIGSA 6 on iron, folic acid and vitamin A supplementation, as well as on exclusive breastfeeding, with regards to the persons who use the health services (see attached table). There are some limitations to this data: since it has not been refined and therefore, shows certain incongruities, there is no information on infant supplementation with iron and folic acid; and, there is no reference to the total population in the Health Area, making it difficult to establish coverage. On the basis of these results, PROSAN is taking the necessary measures to refine the information, and is being supported by *Calidad en Salud* in its official negotiations with SIGSA to use them to calculate these percentages, including those related to infants, on a routine basis.

Limitations

As with all other project components, the limitations experienced during this quarter were the result of not being able to advance in the activities at the Health Area level, in the absence of guidelines from the new authorities.

With respect to the registering of information on the weekly supplementation of iron and folic acid for infants under five and women of reproductive age, and of the vitamin A supplementation, it was not possible through the new SIGSA. The reason being, as already mentioned, the *Unidad Ejecutora* had to stop reproducing them for the 8 DAS.

Finally, delays in transferring reimbursements from the MSPAS to the NGOs working in extension of coverage continued to limit the availability of iron and folic acid required for implementation of the new norm on weekly supplementation.

Table 17-Percentages Of Exclusive Breastfeeding Up To The Sixth Month, Supplementation Of Vitamin A, And Supplementation Of Iron And Folic Acid To Pregnant Women By Health Area

Departments	% of exclusive breastfeeding at 6 months	% of pregnant women supplemented with Folic Acid	% of pregnant women supplemented with iron	% of infants from 6 to < 36 months supplemented with Vitamin A
Alta Verapaz	104,8	87,1	81,1	51,5
Baja Verapaz	76,8	91,1	87,3	68,6
Chimaltenango	84,2	71,0	77,9	101,8
Chiquimula	72,4	94,7	90,1	43,3
El Progreso	71,9	82,8	80,6	60,1
Escuintla	64,0	68,1	60,0	49,2
Guatemala	79,8	98,1	98,3	71,5
Huehuetenango	89,8	78,9	70,8	39,1
Izabal	77,8	59,5	56,6	23,6
Jalapa	69,4	66,2	60,0	71,3
Jutiapa	89,7	61,2	67,4	100,2
Petén	93,3	74,0	74,6	27,7
Quetzaltenango	97,5	64,7	61,7	79,9
Quiché	84,9	84,2	84,6	64,6
Retalhuleu	104,5	71,4	65,2	41,5
Sacatepéquez	93,1	73,1	74,8	75,9
San Marcos	92,7	79,4	80,8	48,4
Santa Rosa	74,3	80,9	81,0	68,7
Sololá	103,0	56,6	59,1	50,8
Suchitepéquez	74,7	68,5	41,5	89,9
Totonicapán	100,9	98,6	97,9	2259,9
Zacapa	68,0	38,5	44,8	47,8
Total	85,6	78,8	76,2	62,7

2.1.5. OR on AEC-PS Results

Introduction

During the first quarter of this year, the following results were obtained in the activities carried out in Operations Research, which is comparing the Extension of coverage model with two variants of this Model: Expansion of Extension of Coverage in Health Posts (AEC- PS) and Expansion of Extension of Coverage with Non-Governmental Organizations (AEC- ONG).

Results

Institutionalization

In San Marcos, the AEC-PS variant of the model has the support and commitment of the MSPAS personnel, who are leading the process with technical support from the Operations Research Manager, the Principal Investigator, the Director and central level staff of *Calidad en Salud*.

Staffing

The San Marcos Health Area personnel have assumed leadership of the process, and are following-up at the local level. Actions have been taken at the central level to assure the counterpart funds for financing the Expansion of Extension of Coverage in Health Posts in San Marcos.

Timeline

90% of the programmed activities for gathering the monitoring and cost information for the final line survey have been completed. Additionally, growth monitoring and promotion (GMP) is being carried out, on a monthly basis, in 56 communities in the three jurisdictions of AEC-PS in San Marcos. The input and analysis of data for the preparation of the final report will be finished during April, to comply with the delivery date of April 30.

Communication

An open and continuous communication has been maintained with the technical team in the Health Area. A monthly meeting on the AEC-PS version of the model is held with the Health Area Directorate (DAS), during which the advances being achieved in the Operations Research indicators are monitored. For this purpose, the service production indicators are used.

Meetings have been held with the new MSPAS authorities in UPS I and the Strategic Planning Department, on the development of the Operations Research process at the level of the Health Area Directorates of the Quetzaltenango, San Marcos and Totonicapán departments.

A meeting with *Pro Redes* and the Principal Investigator has been programmed for April 12, to revise the monitoring and cost information for the draft final report.

Operational Activities

With respect to the variant AEC-PS in the department of San Marcos, all institutional and community personnel are providing health services with Integrated Case Management (MIC) in the three jurisdictions of the health districts of San Marcos, San Pedro Sacatepequez and San Pablo. The most important activities carried out, during the last quarter, with this variant of the model were:

- Supervision: every two weeks, the Health Area Directorate (DAS) personnel carry out supervision and tutorial training activities in the 3 jurisdictions with the support of the Operations Research Manager of *Calidad en Salud*.

Investigation Component

In this component, the most important achievements were:

- **Preliminary Final Report on Operations Research:** the preliminary version has been prepared, and the final report will be completed in April.

- **Monitoring**: ninety percent of the information has been collected for the specific indicators for the Operations Research. The revision and analysis of the information for inclusion in the final report has been programmed for April.

- **Cost- Effectiveness Study**: almost all (90%) of the cost information is ready, and will be included in the final report in April.

Limitations

The AEC-PS variant of extension of coverage depends, to a large extent, on the availability of the resources to be provided by the Ministry. Currently, the problems in this respect are:

- There is no economic liquidity in the MSPAS, and the payments of stipends for the community personnel, per diems, and administrative resources, have been suspended. The situation has upset the community voluntary staff and, additionally, there is the possibility that they will cease to perform their duties.

- There is no guaranteed availability of vehicles for monitoring activities of the health districts by the Health Areas, nor of the jurisdictions by the districts. *Calidad en Salud* has helped provide transport for monitoring and tutorial activities, but this does not assure that, in the future, the MSPAS will have the capacity to provide the same support at the local level.

2.2. Result 2: Adoption of Health Practices within the Home which Favour Child Survival and Reproductive Health

- Increased capacity of the MSPAS and its partner NGOs to design, plan, implement and evaluate behavior change interventions

- Improved health practices in the home through behavioral change interventions

2.2.1. Summary of IEC/BCC Objectives and Strategies

Result 2 corresponds with the IEC/BCC intervention, which lends support to all three major *Calidad en Salud* components: Family Planning (FP), Integrated Management of Childhood Illnesses (IMCI) and the combined Integrated Child, Maternal and Women's Care in the Community (AIEPI AINM-C) strategy with its two complementary components, integrated case management and growth promotion and illness prevention. It has two major objectives, one at the MSPAS and partner NGO central level, and the other at the operative (Health Area, health services and community) level. The first objective focuses on institutionalizing contemporary health behavior change communication (BCC) and interventions (BCI) in the Ministry of Health (MSPAS. Given the change of government occurring at the beginning of 2004, this objective has been reviewed again with the new authorities. In the first quarter of 2004, the *Calidad en Salud*'s IEC/BCC team held advocacy/ coordination meetings with the two communication-related units in the MSPAS -the Health Promotion and Education Department (PROEDUSA) and the Social Communication Unit. The IEC/BCC team continued to coordinate activities and materials' development with other programs of the MSPAS, namely, with the National Immunization Program (PNI), the National Reproductive Health Program (PNSR), and the Food and Nutrition Security Program (PROSAN), and with the National Technical Coordinator of AIEPI AINM-C.

Through the inter-institutional and inter-agency group known as the GTI-IEC[1], the IEC/BCC team continued to provide technical assistance, administrative coordination and financial support for the development of IEC strategies, materials and their implementation. The GTI-IEC met regularly during the first quarter of 2004, and participated in the follow-up workshop to develop the IEC/BCC strategy on sexual and reproductive health of adolescents and youth (SSRA).

The second IEC/BCC objective - improved health knowledge, attitudes and practices of women of reproductive age and mothers of children less than 5 years in the home - is being addressed through technical assistance to the MSPAS in the execution of the three inter-related IEC/BCC strategies for FP, IMCI and AIEPI AINM-C. Through the GTI-IEC, *Calidad en Salud* is also influencing the programmatic focus of its member organizations, most of which are presently implementing the AIEPI AINM-C strategy growth promotion and prevention component. At the institutional level the IEC/BCC strategies for FP, IMCI and AIEPI AINM-C case management component focus on improving interpersonal and intercultural relations, communication and counseling (IPC/C) between providers and users in hospitals, health centers, health posts and community centers. These IEC/BCC strategies also support national campaigns scheduled by the MSPAS and special events during international and national celebrations. The community promotion and prevention component of the AIEPI AINM-C strategy is based on six IEC/BCC tactics that have been developed under *Calidad en Salud*'s integrated communication strategy: 1) mass media (radio), 2) IPC/C between community providers and caregivers during both growth monitoring and promotion (GMP) sessions and home visits, 3) group communication during group and community sessions, 4) special campaigns designed and scheduled by the MSPAS, but requiring local adaptation, 5) educational entertainment during local events and festivities, and 6) community mobilization and participation. The IEC/BCC support system is, thus, intimately linked to *Calidad en Salud*'s Result 4, which reports on community participation and the AIEPI AINM-C strategy.

Despite the slow pace of activities in the first quarter of 2004 due to the change in government, there were some achievements this quarter, which will be summarized in the following sections.

2.2.2. General IEC/BCC Capacity Building

General

IEC/BCC institutionalization plans has included: 1) assisting PROEDUSA and the Social Communication Unit to better define their role as leaders and managers of IEC/BCC interventions, 2) encouraging both the Social Communication Unit and PROEDUSA to take the lead in the GTI-IEC coordination, 3) reviewing lines of communication, role and functions of the IEC Health Area Coordinators and teams, and 4) including IEC/BCC activities in regular annual programming (POA) at the central and area levels.

The new MSPAS authorities has decided that PROEDUSA will be in charge of all health promotion (IEC/BCC) activities, while the Social Communication Unit has more of a public relations role and is in charge of communicating MSPAS activities to the general public through mass media. Changes in personnel occurred in both MSPAS units; the Head of PROEDUSA and most of its staff changed as well as the Head of the Social Communication Unit and other staff. Therefore, considerable time has been required to review with each new counterpart the IEC/BCC theoretical framework, strategic plans, sub-strategies, products, and the on-going material production and distribution process. This orientation has not been completed , but the new PROEDUSA department seems more inclined than the former to follow the IEC/BCC framework and strategic planning proposed.

Regular meetings were held with the new Head of PROEDUSA and a proposal to transfer to that department the *Calidad en Salud* IEC/BCC framework, strategies, methodologies, materials (final arts) and instruments was well received. A detailed transferal plan has been drafted and will be implemented from April to June 2004. Also, PROEDUSA has agreed to coordinate the GTI-IEC and to this end, with technical assistance from *Calidad en Salud*, is conducting a survey of all GTI-IEC members health promotion topics, activities and materials. The formation of

[1] GTI-IEC members include the Social Communication Unit, and the Promotion and Health Education Department of the MSPAS, other MSPAS programs as needed, *Unidad Ejecutora*, ADEJUC/ Promasa, American Red Cross, APROFAM, CARE, Celsam, CRS, *Cruz Roja Guatemalteca*, HOPE, IGSS, JHPIEGO/ MNH, PAHO, PASMO, Population Council, *ProRedes Salud*, Save the Children, SHARE, UNICEF and *Calidad en Salud*.

a MSPAS IEC Council (akin to the GTI-IEC) with representatives from all the major MSPAS programs (normative) and operational units to focus on IEC/BCC issues has been proposed.

The manual of functions of the IEC Health Area Coordinators, the materials' printing/ re-printing procedures, and the monitoring and supervision instruments developed in previous years were discussed. The officialization of the manual as it is does not seem feasible because PROEDUSA wants to distance itself from the previous Ministry so it will produce a manual of its own, albeit taking into account what was developed before. The printing/ re-printing procedures and the monitoring and supervision system and instruments will be addressed as part of the transferal process. PROEDUSA has asked for financial assistance to train Promotion Health Area Coordinators in management, for purchasing a computer and a color printer. The computer and printer will be donated in April, when the transferal process begins in earnest.

Calidad en Salud IEC/BCC participated in several meetings with the MSPAS units and programs: a) with the PNI to provide technical assistance to their IEC/BCC strategy for the Latin America Immunization Week to be held from April 24-30, b) with the PNSR to review materials in progress, c) with PROSAN to develop a proposal to expand AIEPI AINM-C to the remaining 16 Health Areas, and d) with the National Technical AIEPI AINM-C Coordinator to plan for the institutionalization of the strategy and make presentations to new authorities.

Meetings of the GTI-IEC have continued this year. In February the follow-up workshop to develop the IEC/BCC strategy for adolescent sexual and reproductive health (SSRA) was held with technical assistance from *Calidad en Salud*. Technical review was provided to ProRedes to develop a growth promotion counseling video (within the AIEPI AINM-C strategy) and a series of radio programs based on *Calidad en Salud*'s radio spots and its users' guide; to the Population Council for their proposal to implement and evaluate the midwife's strategy to involve men in reproductive health; and to Save the Children for their intervention Saving Newborn Lives to be carried out in Ixil.

The IEC/BCC component actively participated in the development and execution of the advocacy strategy to present AIEPI AINM-C to the Presidential Commissioner to End Hunger, the First Lady and her staff, and the MSPAS Inter-programmatic Coordinator for Nutrition.

Area and Community Level

A workshop of IEC Health Area Coordinators (26 social workers) was held on March 4-5, 2004 with technical and financial assistance from *Calidad en Salud*. In this meeting PROEDUSA presented its present re-organization and new staff, distributed the brief communication plans (*a la carte*) developed last year for main health problems, and discussed the IEC Health Area Coordinator functions. *Calidad en Salud* participated with a refresher talk on IPC/C that should be replicated at the area level together with the distribution of the integrated case management flipcharts (one on child and the other on woman integrated case management). Also, two videos, the ProRedes counseling demo and the *Calidad en Salud* family planning demo were shown to obtain feedback from the social workers. In contrast to IEC Health Area Coordinators´ workshops in the past, PROEDUSA convened the social workers, prepared the agenda and conducted most of the sessions.

2.2.3. Specific IEC/BCC Results for Family Planning

IEC/BCC Strategies

A follow-up workshop to develop the IEC/BCC Sexual and Reproductive Health Strategy for Adolescents (SSRA) was carried out in February 26-27. PROEDUSA, the Integrated Child and Adolescent Health Program (SINA, which will probably become part of the National Reproductive Health Program, PNSR), the PNSR, the HIV/AIDS program, **representative from** the Ministry of Education, PAHO, two youth representative from CONJUVE **(a national youth confederation)** and other GTI-IEC members participated in the workshop. The situational analysis, audiences definition, emphasis behaviors identified in of previous workshop were reviewed. In addition, the IEC sub-strategies or tactics to be used were outlined. A final workshop will be carried out in April to develop specific messages and IEC products to be produced by participating organizations and agencies.

IEC/BCC Training for FP

Several new FP IEC print materials are in progress (currently undergoing technical revision, pretest or final modifications): a brochure on abstinence for adolescents, a brochure on prenatal care, a brochure on men's involvement in RH, an "All about the IUD" poster for providers as part of the re-launching strategy of this method , an "All about vasectomy" poster for providers as part of efforts to increase knowledge and use of this male method as part of the male involvement strategy, a poster with a protracted FP balanced-counseling algorithm, the women's health card, and the Standard Day Method (SDM) User card. Given that these materials were not completed and printed last year, all of them require joint revision and approval from the FP *Calidad en Salud* component, and the new directors of the PNSR and PROEDUSA. To highlight the need for rapid revision and approval they have been included in a list presented to the MSPAS. In addition, the FP video demo has undergone technical review, validation and presently new "takes" are being made in response to the pre-test. It will be completed and reproduced in April.

IEC/BCC Training for FP

Except for the workshop of IEC Health Area Coordinators and financial and technical support provided for health area IEC team workshops in Chimaltenango and Quetzaltenango, no other FP training activities were conducted in the first quarter of 2004. As mentioned, a review of IPC/C was carried out and the sample brief communication plans (plans *a la carte*) developed last year for main public health problems (including short intergenesic interval and low prevalence of use of family planning methods) were distributed by PROEDUSA to the 26 Health Area Coordinators (social workers).

IEC/BCC Monitoring and Evaluation for FP

The monitoring and supervision instruments developed in 2002 and the SIGSA 6 IEC/BCC form developed last year still have to be reviewed and discussed, adapted and adopted by PROEDUSA. Next quarter the transferal process will address this issue.

A summary of FP indicators is presented below under the knowledge, practices and coverage (KPC) evaluation survey conducted in October 200**3**.

Behavior and Product Trial of the Standard Days Method Card

Formative research on the Standard Days Method (SDM) User Card conducted through a contract between URC and the Reproductive Health Institute of Georgetown University ended in January 2004 and a final report was prepared and sent to Georgetown and URC. Also, the report has been presented to the Chimaltenango Health Area and three of its Districts where the research was conducted (Patzún, Poaquil and Zaragoza).

Results of the pre-test and behavior trials of the Standard Days Method (SDM) User Card showed that it is feasible that elegible and motivated women successfully use this natural family planning method. The card was considered suitable, useful and easy to use both by the focus group participants and in the behavior trials. Also, its design and pictures were considered easy to identify and adequate. The main limitation of the card was the paper in which it was printed, which, according to women, is not strong enough to last for six months. In fact, the cards turned in by 24 users after one month of use were dirty and one of them was torn.

A new version of the SDM User card was produced as a result of the test. Since participants indicated that correct use of the method would be facilitated by having a calendar next to the drawing of the necklaces so that they don't forget to circle the date when their period starts, the new version of the card has the six necklaces (for six months of use) and the 2004 calendar together in the central panel. Also, the picture of a couple was added to the front of the card to underscore good communication and negotiation between partners as a requisite to use the method, which is something that participants emphasized.

In exercises conducted as part of focus groups, it was not possible to identify the most prevalent type of error. Level of education facilitates the use of the card, but even two illiterate women were able to use it correctly (one with help

from the husband). However, considering that a few women could not complete all exercises, it was concluded that this tool may be too complicated for a small group of women. Among the factors that make the instructions difficult to follow is the husband not agreeing to use the method or not being sufficiently committed to using it (especially when husband is away from home for long periods of time). Another finding is that husbands tend to doubt the effectiveness of this method.

Practically all the participants in the behavior trial understood the instructions to use the SDM card and were able to use it correctly. Reasons to discontinue its use (in 4 out of 24 cases, that is, 17 percent) were that they did not meet the criteria to use it (especially regarding the minimum duration of the menstrual cycle). The questions posed by some women during the intermediate and final interview were in relation to the meaning of the larger pearl, which marks the first day when the next menstrual cycle could begin.

The great majority of the participants in the behavior trial understood the instructions to use the SDM card and were able to use it correctly. Reasons to discontinue its use (in 4 out of 24 cases, or 17 percent) were that they did not meet the criteria to use it (especially regarding the minimum duration of the menstrual cycle). The questions posed by some women during the intermediate and final interview were in relation to the meaning of the larger pearl, which marks the first day when the next menstrual cycle might begin.

Not anticipated, in both the focus groups and the behavior trials, was the fact that more women preferred to use the SDM User card than the cycle bead necklace, when the latter was presented to them. The main reason for this preference was that the card has both the necklaces (drawing) and the calendar. Lack of a calendar in which to keep track of the dates of their period was the main limitation mentioned about the necklace, although they recognized that the necklace -made of plastic beads- is more durable than the paper card .

A persisting problem is the providers' lack of understanding and practical use of the concept of "duration of the menstrual cycle" (a menstrual cycle starts on the first day of the period and ends the day before the next period) and what having cycles between 26 an 32 days actually means. Following their reasoning, the instructions on who cannot use the SDM should read those that have cycles of less than 27 days (because the darker bead is number 27) and more than 33 days (because the last bead is number 32). Fortunately, the SDM instructions to the woman do not refer to numbers, just to the color/ shape of the beads.

As mentioned, the new version of the SDM User Card is pending authorization for wider distribution and use. Also, the tool is deemed to have potential for use in fertility awareness of adolescents and will be incorporated to the ASRH IEC/BCC strategy.

2.2.4. Specific IEC/BCC Results for IMCI

IEC/BCC Strategies

Technical assistance was provided to the National Immunization Program (PNI) for the design of the IEC/BCC strategy for the Latin American Immunization Week to be carried out on April 24-30 in all countries of the region. The abbreviated IEC/BCC plan for immunizations was shared with them as well as the instruments used in the past to monitor IEC activities (observation of vaccination posts, interviews with authorities and leaders and exit interviews with mothers and other caretakers). A list of priority municipalities (with low vaccination coverage and/or with high neonatal tetanus rates) in the *Calidad en Salud* area of coverage has been developed drawn and distributed to social workers in eight priority areas.

Technical assistance was also provided for PROEDUSA's Healthy Schools Strategy; specifically, a proposal to include AIEPI AINM-C contents such as breastfeeding and complementary feeding of young children (school children often are caretakers of siblings), immunization, ORS preparation and danger signs in the health curriculum of school children in addition to the traditional hygiene component was made. However, given that *Calidad en Salud* does not have a specific strategy outlined with schools, little follow-up has been provided.

IEC/BCC Materials for IMCI

The *Unidad Ejecutora* of the project was to reprint several of the materials developed in support of institutional IMCI this year. However, the UE still has not been able to use counterpart funds for this purpose. Therefore, *Calidad en Salud* is presently reprinting 50,000 vaccination brochures and reproducing 500 CDs with vaccination radio spots using project funds, to be distributed in priority municipalities in the week of April 12-16, prior to the vaccination campaign.

The two flipcharts that were developed for the integrated case management of women and children component of AIEPI AINM-C have also been printed and distributed to health centers and posts in eight priority areas.

IEC/BCC Training for IMCI

A very brief refresher training on IPC/C was conducted in the context of the collaborative study workshop meeting held in March. The low level of counseling in health centers participating in collaborative teams probably reflects the situation in other health centers because counseling was not specifically reinforced in the study's services and only about half of them collected data on counseling indicators. Additional observations of counseling were not carried out because the collaborative study had other priorities, notably institutionalization of the collaborative methodology. However, it is expected that if the IMCI strategy is embraced by the new government more emphasis will be placed in the Growth/ feeding problems evaluation, classification and counseling components of IMCI as part of the strategy to "End Hunger" and prevent malnutrition.

IEC/BCC Monitoring and Evaluation for IMCI

Observations of counseling within collaborative studies was conducted in a visit to four Health Centers in Chimaltenango (two of them participating in the studies and the other two not participating); the observations showed low levels of counseling, but, as mentioned, this topic was only briefly address at the collaborative teams meeting.

A summary of IMCI indicators is presented below under the knowledge, practices and coverage (KPC) evaluation survey conducted in October 2003.

2.2.5. Specific IEC Results for AIEPI AINM-C

IEC/BCC Strategies

In addition to the meetings with new MSPAS authorities, separate meetings were also held with: a) the Presidential Commissioner to End Hunger, b) the First Lady and her advisers and c) the National MSPAS Inter-programatic Coordinator for Nutrition to present AIEPI AINM-C as the priority community level strategy to prevent malnutrition. With the PROSAN and the Inter-programmatic adviser a proposal to expand AIEPI AINM-C to the remaining 16 Health Areas was prepared. In this proposal a third component was added to the AIEPI AINM-C strategy growth promotion and prevention component, nutritional rehabilitation following the positive deviance model promoted by Basics/CORE Hearth projects.

Technical assistance was provided to the First Lady's staff (3) in order to develop a proposal to train a network of 22,000 women volunteers in the growth promotion and prevention component of AIEPI AINM-C.

IEC/BCC Strategies and Materials for AIEPI AINM-C

The only AIEPI AINM-C material that was not printed last year was the Protocol for the Integrated Case Management of Women (includes prenatal and postpartum care, family planning and the neonate up to 7 days). As mentioned in previous reports, integrated case management is mainly curative and it was difficult to structure family planning and prenatal care (which have a preventive focus and rely heavily on adequate counseling) within the IMCI steps of a) ask/ observe, b) classify, c) treat and d) counsel. However, printing of the protocol has started and will be

finished by the beginning of April. The Vigilante Notebook for 2004 was printed by the *Unidad Ejecutora* (paperwork had started since last year) and noteboks have been distributed to priority Health Areas. The ProRedes video on AIEPI AINM-C counseling is being reproduced for the 26 IEC Health Area Coordinators and will be incorporated in IPC/C training.

Several NGOs are presently printing AIEPI AINM-C materials (CARE, Caritas, Curamerica, CRS, Talita Cumi). It has been very difficult to keep track of all of these requests and to comply with providing them a copy of final arts due the reduction in the project's IEC/BCC staff . The contract with Patricia Ceballos, formerly providing follow-up to the AIEPI AINM-C materials, ended in December 2003. Fortunately. This person is now working with ProRedes Salud which has allowed some collaboration to continue.

The IEC/BCC Advisor continues to provide feedback to the Community Participation component of the project. During the first quarter of 2004, the UE printed 1,000 guides on how to set up a situational room, which were distributed to Extension Coordinators and other key personnel in all Health Areas. Also, the community participation methodology was presented to ProRedes who will re-print the methodology manual together with the situational room or *"sala situacional"* guidelines for their own use.

See other AIEPI AINM-C achievements under Result 4.

IEC/BCC Training for AIEPI AINM-C

No training on AIEPI AINM-C was conducted this quarter. However, with technical and financial assistance provided by *Calidad en Salud*, a workshop with USAID NGO partners carrying out the strategy (CARE, CRS, HOPE, ProRedes, and Save the Children) was held on March 26 following a survey on their AIEPI AINM-C activities. In this workshop USAID NGOs agreed to conduct monitoring/ supervisory visits to 25 NGOs in 10 Health Areas to document the manner in which the strategy has been implemented by different partners, including the extension of coverage NGOs. The sample for the field visits was drawn and supervision instruments to be used during the visits were reviewed. A specific protocol for the visits has been prepared by the IEC component and will be distributed to partners before the visits, which will begin on April 12.

IEC/BCC Monitoring and Evaluation for AIEPI AINM-C

As part of monitoring instruments, a summary form to consolidate growth-monitoring data at the community level was developed last year. This summary is key for proper utilization of the community GMP poster in the situational room. Also, another summary form to consolidate growth-monitoring data for all communities under a Community Facilitator can lead to the selection of "at risk" communities (those with 34 percent of more of children under 2 years not growing well). This is an interesting innovation to AIN and will be subject to careful analysis and evaluation. Consequently, with technical assistance from the IEC/BCC component, the *vigilantes'* notebook (where sex, birth date, age, expected weights, actual weights and date of weighing session are recorded) were collected at the end of 2003 and beginning of 2004 to have the data entered for computer analysis.

Over 6,700 (61 percent) of the vigilantes notebooks were retrieved. The data in about half of them has been entered and preliminary analysis on the percentage of children "not growing well" (not gaining minimum weight) by sector, community, jurisdiction and Health Area have been obtained. Results of two Health Areas show a decrease in the percentages of children "not growing well" from one meeting to the next which, if replicated in other Health Areas - point to the impact of counseling/ mothers implementing recommended behaviors on growth (weight gain) of children 0-2 years. In Chimaltenango, 90% of the children who were weighed in the first two sessions, were also weighed in the fourth session; in Sololá, 75% of the children complied with four weighing sessions. This and other analysis on coverage of the intervention and vigilantes errors that will be performed using these data; a detailed plan of analysis was prepared by the IEC Advisor.

Table 18-Percentage of children under 2 years of age who were classified as "not growing well" in consecutive growth monitoring sessions in two Health Areas

Health Area	Growth promotion sessions		
	2	3	4
Chimaltenango	24 (n=3,479)*	23 (n=3,335)	20 (n=3,133)
Sololá	22 (n=1,058)	18 (n=959)	16 (n=796)

*Number of children weighed in this session and the previous one.

As mentioned, starting April 12, *Calidad en Salud* and partner NGOs will carry out joint visits to 10 Health Areas to document/ qualitatively evaluate the manner in which the strategy has been implemented by the different partners, including local NGOs under MSPAS contracts. A protocol for the visits was prepared.

Follow-up Survey on the 2001 Base Line

The IEC/BCC follow-up KPC (knowledge, practices and coverage) rural rapid survey was conducted in the last quarter of 2003, two years after the baseline survey was conducted and the IEC/BCC FP strategy and materials were launched and less than a year after the AIEPI AINM-C strategy started to be implemented. The sample for the new survey was drawn in exactly the same manner as the sample in the previous survey (30 clusters representative of the eight priority health areas, except Departmental capitals). The same questionnaire used in the first survey was used, with a few additional questions on specific IEC activities and materials. The data were entered for computer analysis at the end of 2003; the IEC/BCC Advisor performed the analysis and prepared a final report this quarter.

In conclusion, the level of most knowledge, practice and coverage indicators presented is low, which means that the implementation of the IEC community strategies linked to AIEPI AINM-C need to be reinforced and supervised more intensively. Positive findings of this evaluation are:

The percentages of mothers having heard a specific health message or having received printed materials on main health topics in the last three months increased from baseline to final survey.

- A health provider had visited about a third of respondents in their home; the majority of the visits were from a CHW (promoter, *vigilante* or traditional midwife), and this percentage increased in the final survey. In the baseline survey, topics covered on last visit were mostly related to child health and very few dealt with maternal health or family planning, while in the final survey, all percentages increased, especially those for maternal and child health.

- An increase in the percentages of knowledge (spontaneous or prompted) of contraceptive methods was observed for modern methods, while a decrease was observed for natural methods, except the Standard Days Methods (SDM) or necklace.

- Contraceptive prevalence increased from 55 (15.8 percent) to 93 (25.8 percent) mothers using a contraceptive method at the baseline and final survey, respectively. Use of the three-month injection and the SDM (necklace) increased.

- There was a decrease in total unmet need for family planning (women in union who are not pregnant at the time of the survey and declare that they do not want to become pregnant in the next 2 years or ever, but are not using any contraceptive method) from 78.6 percent at baseline to 64.2 percent at the final survey.

- More non-users knew about family planning provided in MOH health services in the final than in the baseline survey. Likewise, more users obtained method last time in MOH services in the final (62.3 percent) than in the baseline (43.6 percent) survey. There was a considerable decrease in the percentage of rural users obtaining methods from APROFAM.

- 22.9 percent of children less than 6 months were being exclusively breast-fed at baseline and the corresponding percentage increased to 47.9 percent at final survey.

- The percentages of children bottle-fed were lower in the final than in the baseline survey, across all age categories.

- The percentage of mother who said they did not have a card for the index child dropped from 6.2 to 0.9

- The percentage of children who had all the vaccines recommended for their age increased from 61.2 at baseline to 67.5 percent at final survey. In addition, in the final survey 32.1 percent of the mothers had the new child card and were able to show it to the interviewer.

- 85.7 percent and 91.4 percent of children had been weighed in the last six months at baseline and at final survey, respectively. The community center was the place mentioned the most, both at baseline and at final survey; however, percentages for all MSPAS services (community center, health post and health center) as the place where children were weighed last increased in the final survey.

- The private doctor's role in treating diarrhea and respiratory infections in the last two weeks decreased from the baseline to the final survey, while that of the MSPAS facilities (health center, health post and community center) increased. Also, the private doctor is seeing less cases of both diarrhea or ARI with danger sign(s) than the health center and the community center. However the percentage of children with danger signs who received "no treatment" (this probably includes home treatment) increased.

- Percentages for knowledge of general danger signs were higher at final than at baseline survey (this was not the case for specific signs of dehydration and pneumonia).

- Percentages for breastfeeding and complementary feeding reported as preventive measures carried out by the mother increased (this did not happen for other preventive measures, especially treatment of drinking water).

Several of the child and pregnant women indicators showed no significant variation in this evaluation. The most alarming finding was the decrease in the percentage of mother providing adequate complementary feeding at 6-8 months; at baseline it was estimated that about a third of the children 6-8 months were receiving adequate complementary feeding, but only 3.3 percent were receiving the same in the final survey. This finding suggests that the prevalence of exclusive breastfeeding has increased at the expense of timely introduction of complementary feeding at six months. The possibility of increased levels of rural poverty also accounting for this finding cannot be ruled out, also. In addition, prenatal interventions such as vaccination with tetanous toxoid and micronutrients supplementation deteriorated from baseline to final survey.

As it is acknowledged, one limitation of these rapid surveys is their small samples, so that results are approximations. However, most of the results and the direction of change are consistent with the National Maternal and Child Health Surveys (ENSMI) of 1998/99 and 2002. Another limitation was that, due to resource constraints, no separate samples were obtained for communities outside of and within the "coverage extension" model; separate samples would have allowed to better evaluate the effects of AIEPI AINM-C activities. Finally, again due to resource constraints, anthropometry was not included in these surveys.

Annex D presents a table with main results of the KPC comparison between baseline and follow-up survey.

2.2.6. Specific IEC/BCC Results for IGSS

Main results for IGSS during the first quarter of 2004 include printing of AIEPI AINM-C materials adapted for IGSS: prenatal leaflet, postpartum leaflet, breastfeeding brochure, young child feeding brochure, referral leaflet, medicine recall leaflet and FP manual for health educators. These materials were distributed together with training in the adapted AIEPI AINM-C strategy for IGSS in Escuintla and Suchitepéquez.

There was a very promising experience in the Health Center in Villa Nueva, Guatemala, where providers developed their own IEC strategy for IMCI, detailing who provides each type of information and where each IEC support material should be used and/or distributed. The IGSS component of the project has envisioned making of this Health Center a model facility for others to learn from.

The contract with the IEC/BCC team member (Karina Arriaza) who provided technical support to the IGSS IEC/BCC strategy ended March 31. Therefore, she spent some time documenting IGSS experiences and preparing a list and samples of all of IGSS materials for future reference.

Constraints

- The change in the government occurring in January 15 has been a limitation because it has involved devoting considerable time to doing advocacy of major project components (FP, IMCI and, particularly, AIEPI AINM-C) and orientation about the IEC framework, strategies, activities and process of materials design, test and production. In addition, counterpart funds that were to be used in printing/ reprinting IEC materials, among other things, have been "frozen". In Health Areas, lack of counterpart funds have prevented IEC Coordinators from carrying out monthly meetings with IEC teams and have caused them to have to cancel IEC activities such as airing of radio spots.

- During last year, the IEC/BCC team tried to work with both the Social Communication Unit and the Health Promotion and Education Department (PROEDUSA) as partners in IEC/BCC. It is now clear, however, that the latter will be leading the IEC processes and activities in the MSPAS, while the former will have a public relations role only. This change has required a shift in the institutionalization strategy formerly developed.

- The initial reduction in the project's IEC/BCC staff created several constraint this quarter in terms of the production capability of this component. The contract with Patricia Ceballos, formerly providing follow-up to the AIEPI AINM-C materials, ended in December 2003. The contract with the IEC IGSS team member, Karina Arriza, ended in March 31. Given the number of requests from NGOs to provide them with IEC background documents, final arts of different IEC print materials, and master radio spots, additional resources will be needed to adequately respond to them.

2.3. Result 3: MCH Programs and its Partner NGOs are Better Managed

- Management Systems Improvements are implemented to increase effectiveness of MCH Service Delivery
- Improved Program Planning, Monitoring and Evaluation through the Use of Quality Data

2.3.1. Logistics Results and Plans

During the first quarter of 2004, Calidad en Salud continued to work with the MSPAS and IGSS to work towards improving to the logistics systems.

Despite the delay in activities during the first month of the year due to the changes in new Ministry officials, this has been a very productive quarter for the logistics component during which numerous activities and products were successfully finalized and delivered.

During this quarter, the principal accomplishments were: a) training in logistics management to IGSS personnel, b) training in logistics management and in the use of the computerized module for personnel from Internal Auditing of the MSPAS, c) development of contraceptive procurement guidelines for the IGSS, d) support to SIGSA in presenting the logistics module to new MSPAS personnel and in developing a strategy for implementing the module in other DAS with the same success experienced in the DAS of Guatemala, e) performing the first national inventory of contraceptives for the MSPAS, f) development of a logistics calendar for the MSPAS, g) development of logistics tools (FOCUS, Tutorial Digital), and h) completion of a curricula for training MSPAS and IGSS personnel in methodologies for forecasting contraceptive and family planning needs.

Because the achievements are numerous and they themselves subdivided into several components, in this report they are organized into six main sections (introduction to new MSPAS officials, training, support to logistics staff, documents, tools, and other).

Introduction To New Mspas Officials

During the first two months of this quarter access to our counterparts within the MSPAS was limited, but in March several meetings were held to introduce the logistics component to personnel from the new administration.

Meeting with Vice Minister of Health, SIAS, USME, SIGSA, PNSR and USAID: A meeting was held with key ministry personnel to bring them up to date on the progress in the area of logistics management of commodities and in the activities pending for completion under the MSPAS/USAID agreement. Overall, support was demonstrated for all logistics activities and the USME director recognized the functionality and utility of the logistics module. The meeting resulted in a recommendation for a new approach to logistics management, one that considers the integration of a logistics system for contraceptives with that of medicines.

Meeting with Director of USME, Dr. Velia Oliva: The director of the Supervision, Monitoring and Evaluation Unit (USME) held a meeting to review in detail, the plan of action for implementing the remaining logistics activities within the MSPAS/USAID agreement. Overall support for the logistics component was expressed by the USME and the following ideas were exchanged:

- The USME recognizes the achievements of *Calidad en Salud* in the area of logistics management and expressed their appreciation and support.
- The USME will be implementing harsh measurements to ensure proper use of resources for procurement of medicines and to eliminate useless purchases.
- Velia Oliva, Director of USME, recommended that the training in logistics management for new personnel be carried out in the months of May and June 2004.
- Support for the logistics calendar was given, as long as it reflects both contraceptives and medicines.
- The USME requested that the logistics module is installed on Dr. Oliva's computer, and SIGSA was informed and complied.
- The USME advised that the plan to train personnel in methodologies for forecasting future needs of contraceptives will be coordinated directly with Dr. Mendez and the National Reproductive Health Program (PNSR), tentatively to be done in June.

Meeting with SIGSA and the Ministry Adviser of Medicines Dr. Julio Valdez: A one day meeting was held at the DAS of Guatemala with the main objective of reviewing the logistics module and to identify additional capabilities in order to ensure that it meets all requirements for tracking stock levels of medicines and contraceptives at all health care levels. The meeting was very successful and the main conclusions are summarized as follows:

- The logistics module is a good module, if it has been successfully implemented by the DAS of Guatemala (the largest), the experience should be replicable in other areas.

- Good recommendations for improving the module were made, it should include: a) costing, b) providers, and c) levels of stock at all health care levels within the last six months.

- Expand the module in a progressive manner, three DAS at a time so that more quality time can be spent with the staff.

- In order for expansion to take place, the DAS should make a commitment to provide districts with computers and the necessary resources to give them proper support.

- The area of Guatemala could serve as a training center for other DAS implementing the logistics module.

- There will be activities led by *Medicamentos* for standardizing an appropriate basic listing of medicines.

Meeting with current personnel from Internal Auditing and Medicines: As an initiative of the PNSR, this one full day meeting was implemented in order to convey to the new internal auditing the efforts invested in the area of logistics, the processes institutionalized through years of work, and in the importance of the role of internal auditing for ensuring that all regulations and procedures are met. It was a very successful meeting where several aspects are worth mentioning:

- New personnel from internal auditing obtained a good understanding of the importance of the logistics system of medicines and contraceptives and showed commitment to improve stock levels of commodities in-tune with actual needs and demand.

- Participants jointly addressed the main obstacles encountered, including the lack of attitude to improve, the resistance to mechanisms of control, the lack of understanding of logistics by directors, and the need to involve decision makers in the procurement process and to impose harsh measurements to ensure that the funds are properly used.

Support to Logistics Staff

Calidad en Salud's logistics staff supported the counterparts within the MSPAS in several important activities:

- National Level Inventory of Contraceptives: A national level physical inventory of contraceptives was carried out during the month of March. *Calidad en Salud* supported the PNSR taking physical inventories of contraceptives in the DAS of Jalapa, El Progreso, Jutiapa, Santa Rosa, San Marcos, Quetzaltenango and Huehuetenango.

- Lubricants found on several boxes of Condoms: *Calidad en Salud* supported the logistics personnel and jointly carried out an inspection of several warehouses in Guatemala, Chiquimula, Escuintla and Sacatepequez to inspect the boxes and the condoms found were oily with lubrication. A sample was collected and jointly with the UNFPA, the condoms were checked and reviewed. It was concluded by observation, that the condoms were in good condition, the elasticity was adequate, its color and odor where in order, and the packages look well sealed. It was concluded then that the condoms got oily during packaging. The PNSR contacted the DAS where the oily condoms were found to instruct personnel that the condoms were of good quality and that they should not panic and therefore continue to distribute to users.

- Generation of Report by Quarter for Submission to USAID: Support was given to the PNSR in the production of a quarterly report on consumption and CYPs generated.

Training

Despite the inactivity within the MSPAS due to the initiation of the new administration, training activities were implemented in the DAS of Guatemala.

- Training in logistics management for new personnel from the DAS of Guatemala: At the request of the DAS of Guatemala, a two day workshop on logistics management was carried out. During the meeting, *Calidad en Salud* provided limited assistance given that the leadership and know how of the logistics personnel in the DAS has improved significantly. It was a good demonstration of how empowered the logistics personnel is in the area of logistics management, and they showed a high degree of professionalism in carrying out their own training. In the future, this experience should be replicated in other areas, and the personnel of the DAS of Guatemala have offered their services to support others in implementing the logistics management activities.

- Training in logistics management to physicians in charge of supervision within the IGSS: At the request of the Maternal and Child Health Section, *Calidad en Salud* held a two day workshop on contraceptive logistics management. During this workshop the participants received hands on training in logistics, including the concepts, forms used to track vital logistics information, and procedures and regulations of the logistics system within the IGSS. *Calidad en Salud* used this opportunity to give participants a conscience building presentation where the importance of contraceptive logistics management was tied to the overall well being of the Guatemalan population and as part of the strategies for social and economic development.

Documents

Several important documents were completed and finalized during the first quarter of 2003:

- Management design for a logistics system for the program of extension coverage through NGOs: This document was a work in progress and the one that serves as the basis for providing training to over 900 staff members in charge of management of contraceptives through the extension of coverage program. New feedback was introduced and the design was submitted.

- Procurement Guidelines for the IGSS: A set of guidelines that provide step by step instructions to personnel of the IGSS to process requests and payment of contraceptives with the donor (UNFPA). The guidelines were generated so that the personnel in the future could carry out all the necessary steps that will lead to the generation of the contraceptive procurement tables and the negotiations and payments to the UNFPA under their mutual agreement and conditions. This process has been implemented in the past in large part by outside technical assistance.

- Guide for Supervision in Logistics: A guide for implementing supervisory visits for assessing the well functioning of the logistics system and the performance of the logistics staff was improved and a new introduction was generated. The guide has already been institutionalized within the PNSR and has been used for over a year and a half.

- A Study on the Supply and Demand for Contraceptives in Guatemala: The logistics team compiled supply data for the year 2002 from all organizations working in the field of family planning in Guatemala and analyzed it vis-à-vis demand data from the 2002 Health Survey. The study is a first of its kind providing detailed description of market coverage by department and for the nation as a whole. It identifies level of coverage as well as unmet need, quantifying the challenge for ensuring that the Guatemalan couples can realize their right to safe and voluntary family planning services. In addition, the study identifies areas where the organizations can implement actions for further expansion so that they can capitalize on capturing additional markets.

- Logistics Calendar: *Calidad en Salud* generated a draft version of a logistics calendar. The calendar is intended to provide reminders to calendar holders of key logistics messages. A first version went through three revisions with USAID, the PNSR, USME, and with PROEDUSA. Feedback has been received and it

is pending a final meeting to arrive at a compromise prior to reproduction. The main obstacle at this time is the desire to make it a logistics calendar for the whole purpose of medical supplies only, excluding almost in its entirety, the contraceptive supplies for which it was originally conceived.

- Curricula for training in forecasting methodologies: A curricula for implementing a four day workshop on methodologies for forecasting future needs of contraceptives and family planning is planned. As per conversations with USME, this training will take place in the month of May or June.

Tools

Two important support tools where developed by *Calidad en Salud*, these are described in detail as follows:

FOCUS: FOCUS (Forecasting Contraceptive Use) is a contraceptive and family planning forecasting model designed to generate projections for five year plans. Among the key characteristics of the model worth mentioning are the following:

- It is based on marketing information easily obtained from demographic and health surveys.
- It is designed mainly with logistics purposes in mind, it goes directly to the level of demand (users and units of product) and to its implication in terms of cost.
- It generates over 50 tables including changes in population, users of family planning, quantities required by year, cost of those quantities adjusted for inflation, expected level and cost of losses, changes in the method mix, and comparisons by source of services (private, public, commercial, private physicians).
- It runs with any version of Windows (95, 98, ME, 2000, XP, NT).

FOCUS will be included as part of the methodologies introduced to participants during the proposed four day forecasting workshop.

- Digital Logistics Management Tutorial: A simple windows application designed to test your skills in the field of contraceptive logistics management. It is based on an examination of your skills over six sections of ten questions each. The user will be able to monitor its progress as he or she answers the questions. It offers the flexibility to save progress, exit, or to return to complete the exam at a later date. Each set of questions for each section is linked to those sections of the manual that provides the right answer, therefore, the user will be able to get a right answer for a wrong one by reviewing the manual on the screen. The digital tutorial runs with any version of Windows (95, 98, ME, 2000, XP, NT).

The digital tutorial will allow the personnel to test themselves on an ongoing basis and to refresh their knowledge and skills in a dynamic and friendly manner through the tutorial's easy to use interface.

2.3.2. Monitoring and Evaluation Results

Introduction

This year, the project technical support for this component is focused on the institutionalization and completion of the activities both proposed and developed with the MSPAS. Following-up with the proposed activities, continuation was given to the transfer of SAMIG to the MSPAS (UPS1-SIGSA); the AIEPI AINM-C supervision and monitoring system was concluded; and, the process of digitizing the information in the notebooks of the *vigilantes de salud* in the eight priority areas was started. The information systems of the National Commission for the Fight Against Hunger, SIGSA and UPS1 were strengthened through the development and/or restructuring of geo-referenced systems; and, additionally, the operations research was given support in processing the information collected in the cost study.

Objectives of the Monitoring Sub-Component

- Complete the institutionalization of the software packages that were developed with technical support from *Calidad en Salud*.
- Complete the institutionalization of the AIEPI AINM-C supervision and monitoring system that was developed with technical support from *Calidad en Salud*.
- Complete the transfer of the collection, processing and analysis of the principal FP, IMCI and AIEPI AINM-C indicators for the National Program of Reproductive Health.

SAMIG

A group was established to support and accompany the activities of *Calidad en Salud* with UPS1-SIGSA, to verify, guarantee and monitor the SAMIG tool at the national level. Initial contacts with the new authorities were made. These contacts made it possible to inform the new administration of the need to carry out the final validation of the financial administration module. It also is necessary to continue with the training of the NGO's that participate in the extension of coverage process and that are active in the health areas of the Agreement.

In the same manner, understandings were reached with UPS1 on cooperation for providing support for the restructuring not only of the extension of coverage process, but also of the current indicators for certifying the organizations that participate in this process.

SIGSA-SUI

Due to the changes in the 3 P/S and annex 6 forms based on the new norms, support was given to SIGSA to readapt and validate the SAMIG computer tools, in order to be able to capture the data not only for growth control but also for micronutrient supplementation. Additionally, a work schedule was established for updating and producing the instructions and manuals for the already existing information system instruments, as well as the user's manual for the statistics module.

Technical support was offered to begin generating a geo-referenced analysis platform for the information compiled by SIGSA. A commitment was made to collaborate in the training for the personnel in the development unit of SIGSA on how to set up a geo-reference module in the system.

The printing, for the eight priority DAS, of the forms that were modified in 2003, was coordinated with SIGSA and the *Unidad Ejecutora*. These forms are: 3 P/S[2], 3C/S, 5A[3], 5B, 5C, 6 monthly[4], 6 monthly annex, 6 quarterly, 6 quarterly annex, 6 annual, and 18[5]. The decision on which company was to do the printing was made, but it is subject to authorization by the new authorities of the MSPAS.

UPS-1 –MSPAS

A working session was held to present to the new authorities the necessary actions for completing the technical support activities programmed for this year. While it was not possible to immediately reactivate the actions, there was a commitment for further coordination meetings to progressively restart the activities, in accordance with the programmatic priorities.

[2] The 3 P/S and 3 C/S forms are the daily report on consultations at the level of the health posts and centers.
[3] The 5 A, B and C forms are the register of immunizations and micronutrient supplementation for children, women who are pregnant and of fertile age, and adults in general.
[4] The 6 monthly, 6 monthly annex, 6 quarterly, 6 quarterly annex, 6 annual forms are where the information obtained in the 3 forms is consolidated.
[5] The 18 form is the weekly report on obligatory notification illnesses.

As a result of the coordination meetings, a work plan was established for adjusting the UPS1 intranet and reactivating its geo-reference system. The plan also contemplates the training of the personnel that perform process and information analysis, on how to use the tool and the necessary databases for updating this system.

Calidad en Salud

- Geo-Referenced Information System: Technical support was provided for the development of a Supra-Ministerial Geo-Referenced Information System for the Presidential Commission for the Fight against Hunger. As part of this technical support, it was agreed that the system would include information on USAID projects and partners, such as areas in which they are working, coverage and the other important variables.

- Redesign and adjustment of the AIEPI AINM-C monitoring system: Support was given to the completion of the redesign process of the AIEPI AINM-C supervision and monitoring system, which incorporated the observations and modifications made by the central level to the final list of the instruments and indicators. The system consists of 19 instruments and their instructions, and 52 indicators. (See report on supervision and AIEPI AINM-C)

- Electronic Processing of the *Vigilante* Notebook: In collaboration with the AIEPI AINM-C and IEC team, a company was contracted to take charge of electronically processing the *vigilante* notebook. Additionally, in coordination with the UPS1, the delivery of the notebooks from the 8 priority DAS was arranged. 6,467 notebooks were collected, representing 55% of those that had been distributed; these include information on between 35,000[6] to 40,000 children under the age of two years. Table 1 presents the number of notebooks collected and the percentage by area, as well as the advances made in the digitizing process.

Table 19-Total number and percentage of the notebooks collected by health area and progress made in digitizing the information

DAS	*Vigilante* Notebooks Distributed[7]	*Vigilante* Notebooks Received in CS[8]	%	*Vigilante* Notebooks	
				Digitized 1 time[9] (31-3-04)	Digitized 2 times (31-3-04)
Sololá	1021	511	50,0%	Complete	Complete
Quetzaltenango	1010	822	81,4%	Complete	Complete
Huehuetenango	3014	1114	37,0%	Complete	Complete
El Quiché	2519	1089	43,2%	Complete	In process
Ixil	787	464	59,0%	Complete	In process
Chimaltenango	819	697	85,1%	Complete	In process
Totonicapán	1174	657	56,0%	In process	In process
San Marcos	1407	1113	79,1%	In process	In process
Total	11751	6467	55,0%	6 Complete 2 in Process	3 Complete 5 in Process

[6] Estimate of 5 to 7 children per notebook

IO-AEC

As part of the process to help complete the operations research, support was given in the selection of a company, to do the final OR evaluation. The database for studying costs was finished and implemented, the database was installed and the data were reconciled with *Pro Redes Salud* (See the report in the IO AEC-PS section).

Limitations

During this first quarter, the principal limitation was the impossibility of carrying out the programmed activities, due to the lack of approval by of the new authorities

2.3.3. Planning and Programming Results

Results

Development of Management Capacity Building Plan, which Integrates Principles of Quality Management

Calidad en Salud continued with the actions, negotiation and advocacy entailed in the design and execution of a Management Capacity Building Plan directed at the technical teams in the health areas and districts of the MSPAS. This proposal has been recognized by the Vice-Minister and the Director of the SIAS, among others, as a key element for strengthening the human resources in support of the management and modernization of the health sector and the sustainability of the activities that the Program is supporting; additionally, they have stated that the Ministry needs the plan to improve the response capacity of the institutions, for the purpose of achieving better results in the health of the population.

Calidad en Salud was visited by Amelia Kauffman, who participated in the technical analysis of the consultancy proposals for the design of the Management Capacity Building Plan, submitted by the universities invited to participate. It was concluded that the Rafael Landivar University had presented the best proposal, and so work meetings were organized to discuss and adjust the proposed focus and achieve agreement as to the contents and methodologies for developing the plan.

It was agreed that the initial emphasis would be in the design of the Plan and that it would be carried out in one or two pilot Health Areas, using instruments containing defined criteria for measuring the improvement in the management processes and the management performance of the technical teams in the areas and districts; likewise, the criteria would be defined for certifying the improvement obtained through the Plan.

The principal activities of the plan are the following: a) presence sessions, on cycles of 4 months with assignment of tasks to be carried out on-the-job, with the support of a tutor; b) review of the assigned tasks before starting a new session; c) evaluation of putting into practice the subject matter being worked on; and, d) elaboration of a plan for management actions in the area at the end of each cycle.

General Planning

For the purpose of complying with the provisions of the Agreement, *Calidad en Salud* has held meetings with the highest authorities of the MSPAS, to get to know their policies and general guidelines with respect to sustainability of the activities being supported by the project, both at the central level as well as the health areas. The principal activities carried out to achieve this purpose were:

- Development of a matrix for identifying the challenges by component and by program, as well as actual and future actors of the MSPAS; the matrix served to plan out the tactics and the strategies for working in

[7] Information provided by IEC
[8] Information provided by Monitoring
[9] Information provided by the company in charge of digitizing the data

the future with the new authorities (presentations, informative workshops, political lobbying, documentation, advocacy sessions, interviews, actions and negotiation with key actors).

- A document was prepared in response to a request from the Office of International Cooperation of the Ministry for updated information on programs and projects presently being implemented in Guatemala. The document details the dates when the project started and when it is expected to end, the names of the technical personnel and their nationalities, the details of the counterparts by level of health care in the Ministry and other cooperating institutions, together with a technical report on the advances and principal results and achievements of the project to-date. The final section of the document presents the lessons learned during the implementation of the project and recommendations for the future.

- A workshop was held on coordination between the technical personnel of the MSPAS and the project partners of USAID, in which the following aspects were identified by project component: the geographic focus, the levels of health care at which the activities are being carried out, the principal objectives, the proposed goals, the basic activities, the current situation, the resources being contributed and the latest commitments for finalizing the project. During the workshop, working groups were formed by levels of health care, in which a brief presentation was made of each theme and an analysis made of the results and products obtained, and the preliminary steps for continuing and following up on the activities until the termination of the Agreement.

- A document was prepared, presenting by component the activities not carried out in the first quarter of the year and the activities proposed for the second quarter. The document was agreed upon and discussed previously with the technical counterparts of the UE and will be handed over by USAID to the highest authorities in the Ministry. The document is summarized in the following table:

Table 20-Activities not carried out in the first quarter of the year and the activities proposed for the second quarter

COMPONENTS	NOT CARRIED OUT IN THE FIRST QUARTER			PROPOSED FOR THE SECOND QUARTER*		
	COUNTERPART FUNDS	DONATION FUNDS	TOTAL	COUNTERPART FUNDS	DONATION FUNDS	TOTAL
HIV /AIDS	-	Q 20,000.00	Q 20,000.00	Q74,000.00	Q153,000.00	Q227,000.00
Maternal Neonatal Health	Q36,150.00	Q3,600.00	Q39,750.00	Q252,300.00	Q194,235.00	Q446,535.00
Family Planning	120,000.00	Q47,000.00	Q167,000.00	Q 33,000.00	Q 83,000.00	Q 316,000.00
AIEPI AINMC Clinical	Q 3,320.00	Q3,320.00	Q 6,640.00	Q 55,770.00	Q 6,995.00	Q 112,765.00
AIEPI AINMC Community	Q75,000.00	Q 8,500.00	Q83,500.00	2,567,000.46	Q22,000.00	Q2,589,000.46
Community Participation	Q11,040.00	Q 50,000.00	Q61,040.00	Q22,500.00	Q 82,000.00	Q 104,500.00
Information, Education, Communications *	Q557,100.00	Q500,000.00	Q1,057,100.00	Q 722,100.00	Q585,600.00	Q1,307,700.00
Logistics	Q 12,000.00	Q 3,000.00	Q15,000.00	Q 440,000.00	Q 35,000.00	Q 475,000.00
Supervision	-	Q 20,900.00	Q20,900.00	Q 35,960.00	Q20,900.00	Q 56,860.00
Monitoring and Evaluation	-	-	-	Q 119,000.00	Q24,000.00	Q 143,000.00
Planning and Programming	Q 48,000.00	Q 17,000.00	Q 65,000.00	Q 111,000.00	Q 80,500.00	Q 191,500.00
Administrative Financial	Q 23,000.00	Q 2,000.00	Q25,000.00	Q 25,500.00	Q 10,000.00	Q 35,500.00
Operations Research	Q128,000.00	-	Q 128,000.00	Q 130,000.00	Q 10,100.00	Q 140,100.00
TOTAL	Q1,013,610.00	Q655,320.00	Q1,668,930.00	Q 4,614,130.46	Q1,304,330.00	Q 5,918,460.46

* The total amount for the second quarter includes activities not carried out in the first quarter.

The Cost of IEC Materials to be covered by the component is Q2,390,035.00

Development, Implementation of the POA 2004

Calidad en Salud and the *Unidad Ejecutora*, in support of the PNSR, prepared the document on Planning and Programming Guidelines for the year 2004, which it was not possible to implement due to the decision made by the General Management and the Head of the Normative Technical Programs of the MSPAS. The reason for this decision is that the new authorities are carrying out a review of the technical and budgetary execution of the different implementing units and projects under the cooperation and are planning to redefine the process of programming and implementation, through a single *Unidad Ejecutora*.

Coordination

Calidad en Salud supported the redefinition of the scope of work of the area facilitators of the UPSII, for making operational the service activities at the second level of health care. The principal function will be to accompany the activities, give advice, tutorials and monitoring of the activities of reproductive health in the Health Areas, Districts, Hospitals and partner NGOs of the MSPAS, in the components of Family Planning, IMCI, AIEPI AINM-C, Maternal Neonatal Health and Support Systems (IEC, Monitoring, Supervision, Logistics of Medicines and Contraceptives, Planning and Programming and Financial Management and Administration).

Assistance was given to the UPSII and to the *Unidad Ejecutora* for the induction of the area and primary level facilitators; personnel also attended the monthly meetings of these facilitators, to facilitate the discussion of the operational activities and to make suggestions for improving and following-up on the principal components in the Health Areas.

Special Activities

Plan to Institutionalize Quality Assurance in the Health Services

- As part of the process of definition and implementation of a Plan to Institutionalize Quality Assurance in the Health Services, personnel of the UPE have been contacted contracted to hold an initial workshop to analyze and define policies, concepts, methodologies and instruments of Quality Assurance, to be applied in the MSPAS. MSPAS personnel are currently reviewing a proposal for carrying out the workshop and providing support for the institutionalization process.

- During the quarter the Vice President of URC visited the Project to provide technical assistance to the personnel of *Calidad en Salud* and of the MSPAS in carrying out the learning session for the collaborative teams of 17 health districts of the Health Areas of the Agreement.

Limitations

- It was not possible to implement the Planning and Programming Guidelines for the year 2004, by decision of the General Management and the Head of the Normative Technical Programs; this limited the implementation of the activities of the Agreement at the central level and in the Health Areas.

- The disbursement of counterpart funds was not approved for the implementation and execution of activities that should have continued during the first quarter.

- A policy and normative definition is still pending to permit the implementation and continuance of the project activities in the Health Areas.

2.3.4. Supervision – Facilitation Results

Introduction

During this quarter, it was not possible to carry out most of the activities that were programmed. Efforts were focused on negotiating with the new chief of the Supervision, Monitoring and Evaluation Unit of the MSPAS, to reach agreement on the support to be offered to USME during the remaining months of the Agreement. Agreements were also reached on the best way to use the supervision, monitoring and evaluation system, which had been developed and implemented during the administration of the previous government.

Finishing the printing of the supervision instruments

At the end of 2003, the *Unidad Ejecutora* committed itself to print the improved supervision instruments that were not yet printed. During this quarter, 375 instruments for supervision from the central level to the DAS were printed and delivered to USME. Although the quantity of documents printed appears to be too many given the number of Health Areas, these instruments will not only be used by the central level supervisors but will also be given to each Health Area chief so that they know on which aspects they will be supervised. In like manner, they will be distributed to different operational levels at the central level of the MSPAS so that, depending on the support needs of each DAS, they can provide support to the supervision visits, forming technical assistance teams, accompanying the USME supervisors. These operational instances at the central level that receive the supervision instruments are: program chiefs, the head of epidemiology, chiefs of UPS I, II and III, the chief of Services Development and the Director of the SIAS.

Additionally, 375 Supervision Guides from the District to the Health Post were printed and delivered to USME. These will be distributed in the month of April, during an updating activity on supervision-facilitation for district chiefs.

System implementation

During this quarter, the supervision, monitoring and evaluation unit has not followed up on system implementation. However, the DAS of the Agreement have advised, through different channels, on supervision activities carried out.

It is known that in the Areas of Quiché, Ixil, San Marcos and Sololá, supervision teams have been formed and are carrying out supervision visits to the districts. There is still no information on supervision coverage by Area.

Supervision, Monitoring and Evaluation System at the Community Level

The design of the supervision system of the combined AIEPI AINM-C strategy to be applied in communities with Extension Coverage has been finished. The indicators, the flow of the information, instruments, and how the system will function have been defined. This system was developed with the participation of the national coordinator of the combined AIEPI AINM-C strategy, the UPS1, the UE, PROREDES *Salud*, the PSMN and *Calidad en Salud*.

During the month of December, a preliminary test was made of the system and its instruments, which identified opportunities for improvement. The necessary changes have been incorporated in the present version. This system has been reviewed and authorized by Dr. Enrique Molina, national strategy coordinator. Reproduction has begun of the guide, indicators and instruments for this system, which will be socialized during the month of April by the combined AIEPI AINM-C strategy facilitation team in each Health Area.

Agreements with USME for support during this year

Various meetings have been held with the chief of the Supervision, Monitoring and Evaluation Unit of the MSPAS, Dr. Velia Oliva, to establish the support that *Calidad en Salud* can offer to USME during the remaining months of the Agreement, in accordance with the actual needs of this Unit.

With respect to the Supervision, Monitoring and Evaluation System developed during the administration of the previous government, the following understandings were reached:

- USME will take advantage of the support of *Calidad en Salud* in the standardization of the team, with regard to the Supervision, Monitoring and Evaluation methodologies. At this time, 3 persons have left the team of supervisors. The chief of the Unit considers that at least 4 more persons are needed, and they are being selected using an established profile. It is expected to appoint these persons by the end of March and, thus, it would be opportune to carry out the standardization and actualization of the team during the next quarter.

- The supervision instruments used from Health Area to District and from District to Post that were already developed with the support of *Calidad en Salud*, will be used in their present form. The instruments from the Central Level to the Health Area will be modified to respond to the necessities identified by the actual authorities.

- Also discussed was the inclusion in the plans of the actual administration of a reorganization of the programs for attending to the population and, correspondingly, the health care model. Also, changes will be made to the management model. It will be necessary, when these changes take place, to develop instruments that correspond to these models of health care and management, or adapt those that already exist. From this point of view, *Calidad en Salud* considers that the supervision system should correspond to the models of health care and management. USME has been offered support in taking advantage of the lessons learned during the development of the present supervision system, and thus will be able to shorten the time needed for design, testing and implementation. It was also suggested to USME that advantage be taken of the foundations already laid at the local level and the methodologies applied previously, in order to facilitate the development of the new instruments. This process could take time so, for the moment, the system already designed will continue to be used.

- It is the responsibility of USME to monitor the implementation of the supervision, monitoring and evaluation system, which should be done once a month. It is considered that ensuring that the supervision activities are carried out will strengthen the culture of supervision. For that reason, it will be necessary to give priority to programming funds to cover transport and per diems for the teams that supervise at the local level.

Limitations

During the present quarter, the majority of the programmed activities were not carried out. This was due to the change of government and the appointment of a new person to the leadership of USME, the principal counterpart of this component. Although it has been possible to carry out actions and reach agreements with the new chief, the process has been slow and has been achieved by respecting the time needed by her to assume the position, get to know what it entailed, her duties, and to organize her office staff. The USME chief requested that the support activities start as of April.

2.3.5. Financial Management and Administration Results

Introduction

The financial management and administration component in Agreement No. 520-0428 is expected to facilitate the assignment and execution of the government funds for the implementation of those health activities that favor the beneficiary population. Likewise, the application of the administrative and financial norms and procedures by the *Unidad Ejecutora* and the 8 priority Health Areas will contribute to effectiveness and efficiency in the use and management of the financial resources (counterpart funds), to ensure the fulfillment of the objectives of the Agreement.

During the first quarter of 2004, *Calidad en Salud* and the *Unidad Ejecutora* ensured and supported the compliance with, and application of, the norms and procedures established in the manuals, with the purpose of facilitating the procurement of goods and/or services and improving the execution of the counterpart funds, both in terms of quantity and quality of expenditure.

Objectives of the Administrative and Financial Component

The objectives of the financial management and administration component for 2004 were as follows:

- Provide technical support to staff of the *Unidad Ejecutora*, the MSPAS and the eight priority Health Areas of the Agreement, in order to ensure compliance with the norms and procedures related to administrative and financial processes and the management of government counterpart funds.

- Facilitate the development and implementation of an accounting system for the registration and control of counterpart funds.

- Monitor administrative and financial interventions, at central and area level, in conjunction with the UNDP.

Results

Interventions implemented to fulfill these objectives are described below:

Financial Management

Meetings were held with the new authorities of MSPAS (General Management, Financial and Budget Directors), together with the Director and the Administrative and Financial Coordinator of the *Unidad Ejecutora*, to present to them the budgetary and financial requirements for the 2004 counterpart under Agreement No. 520-0428.

Supervision and Monitoring

While reviewing the support documentation for the procurement with counterpart funds of goods and services, using the different contracting methods (petty cash, revolving fund, and payment through administrative action) in the *Unidad Ejecutora* and the 8 priority Agreement Health Areas, it was noted that considerable improvements had taken place in the application of the procedures; however, improvement is needed in the different stages of each procurement and the respective recommendations were formulated.

Calidad en Salud contributed to the following: 1) that the 8 Health Areas presented the liquidation of their revolving fund to the *Unidad Ejecutora* and, in the case of Ixil, San Marcos, Sololá and Quetzaltenango, to the UNDP; 2) that the payments processed against administrative action which were presented to the *Unidad Ejecutora* and to the UNDP were not questioned, and that there was financial execution using this mechanism; 3) that the 8 Health Areas and the *Unidad Ejecutora* complied with the established procedures under the different contracting mechanisms; and, 4) that there was an improvement in the registering of the execution of revolving funds and inventories, and controls over fixed assets, supplies, fuel and vehicles.

The following table shows the execution by the 8 Health Areas and the *Unidad Ejecutora* of counterpart funds, which were assigned in December 2003, by means of petty cash, revolving funds, and payments through administrative action; not included are the salaries during the first quarter of 2004 of key personnel in the *Unidad Ejecutora*.

Table 21-Execution of the counterpart funds, 1st quarter of 2004 (amounts in Quetzales).

	Petty Cash and Revolving Fund		Executed through administrative actions
	Assigned	Executed	
Ixil	143,227.00	90,371.37	58,051.61
Huehuetenango	259,000.00	Pending liquidation	52,001.96
Chimaltenango	84,000.00	Pending liquidation	112,278.44
Quiché	350,000.00	Pending liquidation	0.00
San Marcos	250,000.00	249,875.18	0.00
Sololá	63,000.00	62,979.36	0.00
Totonicapán	*434,800.00	Pending liquidation	0.00
Quetzaltenango	150,000.00	149,303.68	0.00
Unidad Ejecutora	180,000.00	Pending liquidation	186,771.16
Totals	1,914,027.00	552,529.59	409,103.17

* In the case of Totonicapán, the amount assigned in petty cash and rotating fund consists of Q157,800.00 transferred in December 2002 and Q277,000.00 transferred in April 2003.

Coordination

Calidad en Salud and the *Unidad Ejecutora* held meetings with staff from the UNDP, UDAF partner projects and the Health Areas for i) planning, programming and coordinating technical, administrative and financial activities; ii) evaluating interventions, and analyzing problems and constraints on budget and financial execution; and, iii) improving the procurement of goods and services.

Information regarding the technical and financial progress of the Agreement was presented to staff from the Public Finance Ministry (*Dirección de Crédito Público*), MSPAS (*Unidad de Proyectos y Cooperación Internacional de Planificación Estratégica, Gerencia General Administrativa-Financiera*), USAID, *Calidad en Salud* and the *Unidad Ejecutora*.

Training

During the first quarter of 2004, *Calidad en Salud* carried out activities to improve the quality of the budgetary and financial execution of counterpart funds and, to that end, tutorials were conducted for technical, administrative and financial staff of the *Unidad Ejecutora* and the 8 health Areas, responsible for: 1) managing the different contracting mechanisms for goods and services; 2) register and control of fixed assets; 3) fuel management; 4) warehouse management; and 5) use and maintenance of vehicles and equipment. Information and orientation activities were carried out with these staff members, in order to update and provide feedback on the norms and procedures (petty cash, revolving fund, and payment through administrative actions) and internal control in order to improve performance in carrying out their work.

A workshop on norms and procedures for managing petty cash, revolving funds, and payments through administrative action, was held for the 6 area facilitators of PNSR/UPSII, primary level facilitators, the financial director, and monitoring staff contracted by the *Unidad Ejecutora*.

Other Activities

Within the framework of UNDP, support was given to the elaboration of the 2004 budget for counterpart funds for the *Unidad Ejecutora* and the 8 Health Areas.

Calidad en Salud gave support to the *Unidad Ejecutora* in the delivery of 7 sets of computer equipment (equipment with its respective UPS and printer) to the Chimaltenango Health Area and 4 to the Huehuetenango Health Area.

A matrix was elaborated which contained all the elements to be considered in order to be familiar with the work carried out under the administrative and financial component of the USAID/*Calidad en Salud* program with the MSPAS. It was presented to the workshop on coordination between the MSPAS and the USAID project partners.

A matrix containing the description of activities programmed for the second quarter of 2004 for the administrative and financial component was prepared with support from *Calidad en Salud*.

With support from *Calidad en Salud*, the *Unidad Ejecutora* codified and registered in the accounting system, the budgetary and financial information related to counterpart funds for the years 2000 and 2001.

Limitations

Despite the actions taken with the MSPAS, it has not yet been possible to secure any assignment of counterpart funds for this year.

The reorganization process being carried out by the new authorities in MSPAS has been very slow.

The 8 Health Areas and the *Unidad Ejecutora* do not yet have any counterpart funds to finance activities under the Agreement, due to the limitations established by the new authorities in the MSPAS, because: 1) there has been no programming; 2) the new Health Area Directors and Managers have only recently been contracted; and, 3) a re-organization is being carried out.

The process of coding and registering in the accounting system the documentation for the execution of counterpart funds in the *Unidad Ejecutora*, is proceeding very slowly due to the lack of human resources and other problems connected with the server and the network; these latter ones were resolved support from *Calidad en Salud*.

With respect to human resources for the administrative and financial area of the *Unidad Ejecutora* (chief financial officer, monitoring staff, and computer technician), the new authorities only authorized their contracts for two months (January and February 2004), and only the Health Areas of Huehuetenango and Ixil have an auxiliary administrative-financial staff member contracted with counterpart funds.

2.4. Result 4: Greater Community Participation and Empowerment

- Community Members Actively Participate in Decision-making Concerning MCH Programs
- Greater Community Control Over Factors that Determine Health Status

2.4.1. Community Participation Sub-component Results

Introduction

Result No. 4, is described as "Greater Community Participation and Empowerment"; the objectives of this result are to increase community responsibility in the improvement of health care services, as well as improve household health practices. These objectives are to be achieved through the following strategies: 1) support for the training of the community health care personnel and other community agents in basic management themes, community participation in IMCI and family planning, and 2) design and expansion of the improved processes for community mobilization[10]. Apart from these original strategies, there is what is currently considered a third strategy, the implementation of the analysis of the community situational room for decision making at the community level.

Taking into account the already mentioned results, in this quarter there were activities related to coordination and planning, tutorials, and follow-up to the production, reproduction and distribution of materials. These activities are described in more detail below.

Planning and Coordination

- Participation in the and presentation of the AIEPI AINM-C strategy to the new authorities of the SIAS and UPS1, with its support components including community participation. During the presentation, a copy of the community participation manual was shared and the activities carried out, the achievements, the activities that require follow-up and the cost that this implies, were presented. In this presentation, it was concluded that the authorities of the MSPAS would carefully review the strategy, its components and the materials, and that they will analyze the possibility of continuing with it, and expanding activities to the national level. The MSPAS authorities were interested in carrying out more specific workshops to help them learn more about the strategy and its components.

- In coordination with the *Unidad Ejecutora*, actions were taken to obtain counterpart financial resources for the reproduction of the "Guide on How to Make a Community Situational Room", of which 1,500 copies were printed.

- Participation in the workshop to reach agreement to implement the learning visits to the NGOs of the PEC, of *Pro Redes Salud,* and for partners of USAID, who have implemented the AIEPI AINM-C strategy. During the workshop, the checklist for verifying the community situational room was socialized, and will be applied in the learning visits.

Follow-up and Tutorials

Three health areas were visited: Chimaltenango, Totonicapán and El Quiché, for the purpose of providing tutorials on the implementation of the community participation methodology; of these three health areas, only Totonicapán has initiated the analysis of the community situational room with the key actors from 6 communities. Technical and financial support was given to the other two health areas to carry out reinforcement in implementing the community participation methodology, the indicators of the component and the monitoring instruments. Between the two areas

[10] Strategic Plan

(Quiché and Chimaltenango) a total of 94 health care providers received this reinforcement (28 TSR, 33 FI, 25 MA and 8 AE). The rest of the health areas expect to carry out this same activity during the month of April.

Materials

In November 2003, the manual on community participation and the guide for developing the community situational room were presented and officially distributed to the 20 health areas with extension of coverage; it was agreed that these documents were to be distributed in 2004 to the NGOs certified by the MSPAS. To date, the manual has been distributed in the following manner Table 22.

Table 22-Distribution of the Manual on Community Participation

Health Area	Institutional Facilitators	Technicians in Rural Health	Subtotal
Chimaltenango.	11	13	24
Sololá	13	5	18
Totonicapan	10	10	20
Quetzaltenango.	14	15	29
El Quiché	25	35	60
Total	73	78	151

On the other hand, modifications have been made to the guide for developing the community situational room, including the format for obtaining the information on family planning. Having made the mentioned modifications, the *Unidad Ejecutora* requested the funds for the reproduction of 1,500 guides, which were distributed by UPS1 to the health areas of the Agreement. The Unit decided to distribute them to the institutional facilitators and community facilitators, since they are responsible for promoting the analysis of the situational room in the community Table 23.

Table 23-Distribution of the guide for elaborating the community situational room.

Health Area	Total received by Health Area.
Chimaltenango.	67
Sololá	88
Totonicapan	73
Quetzaltenango.	88
El Quiché	209
San Marcos	104
Huehuetenango	404
Ixil	75
Total	1,108

In the second quarter of this year, it is expected to reproduce another 3,000 guides for the remaining community centers in Guatemala and a folder with the formats of the physical/actual situational room for each community

center in the eight priority health areas. The purpose of this is to facilitate the development, presentation and analysis in the community of the community situational room.

Institutionalization

The MSPAS has started to institutionalize the community participation methodology, in that it has been included in the "guide to develop proposals to renew agreements for the provision and administration of basic health services" that the NGO providers and administrators of health services have to present in the year 2004; the methodology is considered to be a strategy for improving the services.

Limitations

The re-certification of NGOs by UPS1 has not permitted the immediate distribution of the community participation manuals, or the implementation of the community situational room.

The lack of the implementation of the supervision and monitoring system of AIEPI AINM-C on the part of the MSPAS has contributed to not attaining the tracer goals and indicators (% de community centers with a physical situational room and % of communities in each jurisdiction that has a local action plan).

2.4.2. AIEPI AINM-C Promotion and Prevention Component Results

Introduction

The AIEPI AINM-C strategy focuses on two basic interventions: 1) Integrated Case Management and 2) Promotion and Prevention, which include the four steps of the community participation methodology. *Calidad en Salud* has strengthened the extension of coverage process in the eight health areas of the Agreement No. 520-0428. The Promotion and Prevention component is very closely tied to Result No. 4 because of the participation of the *Vigilantes de Salud* (VS) in growth monitoring and promotion and in the health care of the mothers of children under the age of two.

During the first quarter of this year, there was a change of government, as well as of the authorities of the Ministry of Public Health and Social Assistance (MSPAS). *Calidad en Salud* focused its technical assistance in advocating for the institutionalization of the AIEPI AINM-C strategy with several political, technical and operational levels. Also, planning and coordination activities related to advocacy, and the institutionalization of the activities already implemented, or in the process of being so, in the health areas were carried out with officials of the MSPAS and the NGO partners of USAID.

Presentations were made, and training materials and monitoring and supervision instruments for strengthening the information system, assigned to the *vigilantes de salud*, were distributed. Furthermore, the visits to learn from actual experiences in implementing the AIEPI AINM-C strategy were organized and communicated to officials at the central level of the MSPAS and of the NGO partners of USAID.

Institutionalization

Meetings were held with the new officials of the MSPAS, to present the AIEPI AINM-C strategy, with emphasis on the growth monitoring and promotion component; this component is linked to the government policy on the Fight against Hunger.

Presentations on the strategy were made to Andrés Botrán, designated as the Presidential Commissioner for "The Fight against Hunger", to Wendy de Berger, first lady of the nation, and to Dr. Ricardo Blanco, the inter-programmatic coordinator within the Ministry, who is currently responsible for reorganizing the programs of the Ministry of Health. Also, a presentation was made to Dr. Jaime Gómez, new Vice-Minister of Public Health and

Social Assistance and to other technical actors of the normative programs. They also received copies of the strategy materials.

Dr. Ricardo Blanco was taken on a field visit to the Chimaltenango Health Area, where he observed a meeting on growth monitoring and promotion, in the community of El Retiro in the municipality of San Martín Jilotepeque. There was good attendance by mothers of children under two at the meeting. The community personnel performed very well in applying the strategy and adequately used the methodology and the materials.

As a result of these activities, technical support was given to the Secretariat of the Social Work of the Wife of the President (SOSEP), to develop a proposal to request funds from private individuals in Japan, to implement growth monitoring and promotion of children under two at the national level, through a network of 22,000 women connected to the SOSEP. The reply to this proposal is still pending, in order to put into practice its implementation and execution.

Calidad en Salud participated in a workshop on coordination between the highest authorities of the MSPAS, USAID and each one of its project partners. The conclusions formulated during the workshop by the group representing the first health care level, are the following: a) the IEC materials used in the strategy are of very good quality; b) there will be a review of what is functioning well in the strategy in order to continue its implementation; and, c) workshops will be organized to enter into more detail regarding the specific contents of the strategy.

Planning and Coordination

Calidad en Salud carried out coordination and planning activities with the new officials of the MSPAS, in order to define the follow-up activities. Coordination and planning meetings were also held with the General Directorate of the SIAS (General Management, Development of Programs, USME, PROEDUSA and UPS1), to coordinate technical support for the reproduction, supply and distribution of IEC materials to support the prevention activities against the *Rotavirus.*

Calidad en Salud coordinated with the *Unidad Ejecutora* and the National Program for Reproductive Health to develop work guidelines for programming activities in April. With the *Departamento de Regulación de los Programas de Atención a la Personas*, the planning and coordination for the visits to learn from actual experiences in the implementation of the AIEPI AINM-C strategy took place. Also, a presentation was made on the supervision and monitoring system at the community level to personnel at the central level of the MSPAS and NGO partners of USAID (CARE, SHARE, SAVE THE CHILDREN, CRS, *Pro Redes Salud*, Project HOPE).

Development of IEC materials

During the present quarter, *Calidad en Salud* supported the UPS1, the Normative Technical Coordinate of the strategy and the *Unidad Ejecutora* to develop a distribution plan for the new *Cuadernos de Vigilantes de Salud* (Record Notebooks) in the health areas covered by the contract, detailed in the Table 24.

Additionally, in coordination with *Pro Redes Salud*, the following materials were delivered to the health area of Huehuetenango: 1,000 bags, 1,000 copies of *láminas* No. 1 of counseling, 500 copies of *láminas* No. 2 of counseling and 1,000 copies of *láminas* No. 3.

Training

With the technical support of Calidad en Salud, a training workshop on "Puesta en común para la realización de las visitas de campo, para obtener información sobre la situación actual de la implementación de la estrategia AIEPI AINM-C" in the Health Areas of Chimaltenango, Sololá, Quiché, Ixil, Totonicapán, Huehuetenango, Quetzaltenango, San Marcos, Chiquimula and Baja Verapaz. Was conducted 19 persons participated from the following institutions: SHARE, CARE, CRS, Save The Children, HOPE, PROREDES, Unidad Ejecutora, Ministry of Health, USAID and Calidad en Salud.

As a result of the meeting, all the participating institutions committed themselves to contribute the human resources, travel expenses and vehicles for the field trips. It was agreed that the next meeting would be held in April, in the C*alidad en Salud* office, to prepare the logistics of the field trips.

Implementation

The implementation of actions in the health areas and districts was not given continuity because of the absence of the responsible personnel in the areas (vacations), change of authorities, normative technical decisions and the absence of counterpart resources for the follow-up. However, as a result of the implementation during the first quarter, the following quantities of the *vigilante* notebooks were received with data on growth monitoring (which is being analyzed and processed):

Table 24-Distribution the *Cuadernos de los Vigilantes de Salud*

DAS	*Cuaderno del Vigilante* Distributed	*Cuaderno del Vigilante* Received	%
Chimaltenango	819	697	85.1
Sololá	1,021	511	50.0
Quiché	2,519	1,089	43.2
Ixil	787	467	59.0
Totonicapán	1,174	657	56.0
Huehuetenango	3,014	1,114	37.0
Quetzaltenango	1,010	822	81.4
San Marcos	1,407	1,113	79.1
TOTAL	11,751	6,467	55.0

Supervision, monitoring and evaluation

The supervision and monitoring system at the community level of the AIEPI AINM-C strategy, designed jointly with the normative technical personnel of the MSPAS (*Coordinador Técnico Normativo*, personnel of the UPS1 and UE), was presented to the personnel of the NGO partners of USAID (CARE, SHARE, CRS, SAVE THE CHILDREN, PRO REDES and *Proyecto* HOPE). Agreement was reached on the criteria for managing the specific instruments of Integrated Case Management and of Promotion and Prevention.

Reinforcement activities in the supervision and monitoring system were agreed-upon and coordinated for personnel in the areas, health districts and NGOs working in coverage extension; the agreement established by the normative technical coordinator with the *Jefe del Departamento de Regulación de los Programas de Atención a las Personas* was to carry out the activities in two work groups during the month of April, one in Quetzaltenango and the other in Chichicastenango or in Panajachel, being strategic points for the health areas.

Limitations AIEPI AINM-C Promotion and Prevention Component

- Minimal advancement in the follow-up to the implementation of the strategy, due to the change of authorities and of key personnel in the Ministry of Health at the central and area level.

- Lack of participation in the strategy activities by Ministry personnel, due to the reorganization in the programs and in staff functions.
- No follow-up to strategy implementation, due to the vacations in the health areas and districts.
- Difficulty in executing follow-up strategy activities at the central level and in the health areas, due to the absence of counterpart resources.
- Difficulty of finishing the training sessions for the *Vigilantes*, which were pending from the year 2003, in some of the health areas due to the delay in the disbursements for the NGO administrators of basic health services.

3. RESULT 5 IGSS: IMPROVED USE OF VARIOUS MATERNAL-CHILD HEALTH SERVICES PROVIDED BY THE IGSS

3.1. Sub – Result 1: More families use Maternal-Child Health Services

3.1.1. Family Planning Results

The decision to limit the family planning services resulted in a negative impact on production, as much in new users as in couple years protection, and taking the decision to plan an increase in the annual target for 2004 of only 2.5% in relation to the results obtained in 2003, while awaiting a quick and favorable resolution of the problem.

Indicators

Production of new users of the methods, as per the target for 2004

During this first quarter of 2004, 7,023 new couples started using birth spacing, camping with 22.5 % of the goal anticipated for the current year. . Quarterly injectable continue to be the preferred method.

New Accepotrs of FP by Method, 2003

Table 25-New acceptors of FP by method, 2003

NEW USERS IGSS 2004					
FP Method	**1Q**	**Total**	**Target**	**%**	**Mixture**
AMP	2.786	2.786	14.081	19,8	39,7%
Condom	1.379	1.379	5.779	23,9	19,6%
IUD	502	502	2.248	22,3	7,1%
Implants	44	44	179	24,6	0,6%
Oral Contraceptives	589	589	2.526	23,3	8,4%
AQV-male	36	36	324	11,1	0,5%
AQV-female	1.389	1.389	5.405	25,7	19,8%
Natural Methods	298	298	651	45,8	4,2%
Total New Users	7.023	7.023	31.193	22,5	100,0%

CYP Production as per 2004 Target

The AQV-female is the method that produces the greatest quantity of CYP, followed by quarterly injectables.

Table 26-CYP production by method and 2004 target

CYPs IGSS 2004					
FP Method	**1Q**	**Total**	**Target**	**%**	**Mixture**
Depo Provera	4.598	4.598	21.933	21,0	18,8%
Condom	1.167	1.167	5.030	23,2	4,8%
IUD	1.757	1.757	7.868	22,3	7,2%
Implants	154	154	627	24,6	0,6%
Oral Contraceptives	798	798	3.682	21,7	3,3%
AQV-male	396	396	3.564	11,1	1,6%
AQV-female	15.279	15.279	59.455	25,7	62,5%
Natural Methods	283	283	1.071	26,4	1,2%
Total CYPs	24.432	24.432	103.230	23,7	100,0%

AQV-F Interventions

62% of the AQV-F is for postpartum or birth spacing.

Table 27-AQV-F interventions

AQV-female	**1Q**	**Total**	**CYPs**	**% CYPs**
Cesárean	528	528	5.808	38,0
Post-Partum	642	642	7.062	46,2
Post-abortion	18	18	198	1,3
Between Pregnancies	201	201	2.211	14,5
Total	1.389	1.389	15.279	100,0

Natural Family Planning (NFP) Methods

298 New Users of Natural Methods.

Table 28-New acceptors of NFP

Natural Methods	New Users	Total	CYPs	% CYPs
	1Q			
MELA	179	179	45	16
Beads	119	119	238	84
Other	0	0	0	0
Total	298	298	283	100

Moment of IUD insertion

The majority of IUD are inserted in between pregancies.

Table 29-IUD insertions per services facility

IUD Insertion	New Users	Total	CYPs	% CYPs
	1Q			
Between Pregnancies	489	489	1.712	97
Post partum	10	10	35	2
Post abortion	3	3	10	1
Total	502	502	1.757	100

Monitoring and Performance Indicators

Support and technical assistance continued to be provided to the two training centers (*Gineco Obstetricia* and Dr. JJ Arévalo Hospitals), to the technical group for women's health, and to the commission appointed to issue a report on the access and right to family planning services.

The supervisors of the Medical Audit, Supervision and Control Department received training on the logistical administration of contraceptives, completing 100% of the target for personnel trained.

Table 30-Monitoring and Performance Indicators

Indicator	Target for 2004	% Reached
CYP	103,228	23.7
New Users	31,193	2.5
Governing Board grants official status to FP program	100%	50
Monitoring and technical assistance for the training centers	100%	50
Monthly technical assistance to the group for women's health	100%	50
% of service personnel and supervisors trained in logistical administration of contraceptive methods (supervisors not included in figure)	100%	100
% of services with tutorials	65%	60%

Training

An in-service training was carried out in the clinic in the department of Jalapa to provide assistance and follow-up, and to improve the provision of family planning services and the systems of counseling, IEC, logistics and information. A total of 10 persons were trained, including nurses, auxiliary nurses, social workers and administrative staff.

3.1.2. AIEPI AINM-C Results

The official status given to the IMCI Strategy was achieved by means of a Management Agreement, that not only approved the Manual for the Integrated Management of Childhood Illness and its application at the primary care level, but also indicated that it should be known at levels II and III with the purpose of establishing a controlled follow-up on referrals and contra-referrals.

The Department Directorates were designated for the local supervision and monitoring of the strategy, and the Medical Audit, Supervision and Control Department together with the Maternal Child Section for the monitoring and supervision at the central level.

Monitoring and Indicator Compliance

With the training of the child care personnel of the clinic in Antigua, Guatemala, and of the medical residents from the pediatric post graduate program, in the application of the IMCI strategy, 100% of the service providers and 98% of the personnel trained to apply the IMCI strategy, were reached.

Technical support was continued, not only for the training centers already formed, but also for the technical group for children's health.

This first quarter of 2004 marked the start of the implementation and development of the AIEPI AINM-C strategy at the community care level in the Escuintla and Suchitepéquez departments, with the support of the 24 facilitators trained in December 2003, as well as the accompaniment of the Training and Development Division of the Human Resources Department and the authorities of the Department Directorates in both departments. The process of training 100 % of the personnel in the basic health teams was completed.

As an important complement, the personnel at levels II and III were inducted, in order to get to know the strategy, its application and materials, as well as how to establish a network of opportune references and counter-references to improve communications at the three health care levels.

As a result of an in-service training on the application of the IMCI strategy in pediatric care unit in Villa Nueva, authorities and service providers, approved the creation and development of this unit as a model and training center for the IMCI strategy.

The unit of Villa Nueva (level II) is the most recent care center in the IGSS, and provides attention exclusively to children under the age of five years, and has a production of more than 300 consultations a day. Calidad en Salud accepted the challenge and offered to provide the necessary technical assistance and logistic support so that, in the short-term, the unit applies the IMCI strategy complying with the process of care as laid out in the technical norm and its different components (IEC, supplies, information, investigation and supervision, monitoring and evaluation).

In 2003, for the Department of Suchitepéquez, the percentage of children 0-12 months old with a complete set of vaccinations was analyzed and the following were the results: for a population of 1,860 children, 0-12 months old, 98.1% were vaccinated with 3 doses of diphtheria or DPT, 99.4% with BCG, 85.3% with two complete doses of polio and 71% with measles or MMR. If the number of children that received the above-mentioned vaccinations is considered, it can be summarized that 71% of children with the right to services in the Department of Suchitepéquez have received a complete set of vaccinations by age one.

In the IGSS, the clinical card for children from the Latin American Perinatal Center (CLAP) is used as the official clinical record of the Institute. One of the principle weaknesses of using this card has been the in-complete record of information; the weight and height of a child are recorded on the card, but there is no way to determine the nutritional status of a child based on this information. After implementing the strategy, doctors agreed to practice a procedure that would allow them to measure nutritional status of a child as well.

In order to confirm whether or not the nutritional status of the children was being determined, clinical cards from 3 service units of the Institute were reviewed, and the following was encountered: 90% of 925 cards from the Pediatric Hospital, 100% of 376 cards from the Amatitlán doctor's office, and 75% of 348 cards from the San Lucas Toliman doctor's office showed the nutritional status of the children.

Table 31- Monitoring and Indicator Compliance Table

Indicator	Target for 2004	%
% of child care personnel trained to apply the IMCI strategy	90%	98
Official status for the IMCI strategy granted by Management Agreement	100%	100
Training of pediatric residents in application of IMCI strategy	100%	100
Induction in the AIEPI AINM-C strategy at levels II and III in the departments of Escuintla and Suchitepéquez	100%	100
% of basic health teams in Escuintla and Suchitepéquez trained in the application of the AIEPI AINM-C strategy	90%	100
% of the auxiliary nursing students trained in the application of the AIEPI AINM-C strategy	100%	100
Monthly monitoring and technical assistance for training centers	100%	50
Monthly technical assistance to children's health group	100%	50
% of case records registering nutritional status	75%	90[11] 100 85
Creation and development of a model attention unit and training center in IMCI strategy	100%	25
% of completed vaccination for children 0-12 months	80%	71[12]
% of children less than 6 months who are exclusively breastfed	50%	27[13]
% of ORT usage or intake of liquids during episodes of diarrhea	75%	100[14]
% of pneumonia cases treated by service providers according to the norm	85%	100[15]

Training

In the table on trained personnel, of note during the first quarter of 2004 is the performance shown in training the basic health teams in how to apply the AIEPI AINM-C strategy, exceeding the planned target of 300 members of the personnel, by reaching 377 (126%), and the induction of levels II and III.

[11] Corresponds to the analysis of clinical cards from the following units: Pediatric Hospital, Amatitlan and San Lucas Toliman.
[12] This IGSS indicator is difficult to measure, since access to vaccination is only given if the parents of the child are working and have accredited rights, every three months. The population is variable.71% of the figures correspond exclusively to the Department of Suchitepequez in 2003.
[13] The % of children under the age of six months being exclusively breastfed is difficult to modify and must take into account that the working mothers return to work 54 days after giving birth. In an analysis of 1,121 cases in the pediatric hospitals and clinics, Quiché, Escuintla, Amatitlán and San Lucas Tolimán, it was found that 27% of the mothers give exclusive breastfeeding, 65% mixed and 8% with no breast feeding.
[14] Results from review of 1,723 clinical files, daily and weekly registration sheets from the Pediatric Hospital.
[15] Results from review of 1,723 clinical files, daily and weekly registration sheets from the Pediatric Hospital.

Table 32- Summary of personnel trained in the first quarter of 2004

AIEPI AINM-C	Docs.	Nurses	Aux. Nurses	T.S	Adm	Prom	Educ	Other	M	F	Total	Goal	%
Application of the strategy AIEPI	25	1	9	1				2	16	22	38	30	127%
Induction in AIEPI AIMN-C	42	24	1	7	5	26	1	11	68	49	117	117	100%
Application of the AIEPI AIMN-C strategy	42	39	129	18	1	132	9	7	127	250	377	300	126%
In-service Training	9	2	3	2	15			4	15	20	35	30	117%
Total	118	66	142	28	21	158	10	24	226	341	567	477	119%

3.1.3. IEC Results

Introduction

Being an integral part of the AIEPI AINM-C strategy, the IEC materials were designed and validated in a joint process with personnel from the primary care level in the Escuintla and Suchitepéquez departments, obtaining an excellent product adequate to the understanding and needs of the Institute's users.

The algorithm developed in the last quarter of 2003 to satisfy the needs of the service providers, has converted itself into a very useful and accepted tool. It is worth highlighting that from the point of view of health care, it is not only useful for the provider, but is also used as a visual aid in orienting the users.

Materials, Norms and Guidelines

The design, validation, reproduction and distribution of the IEC materials of the AIEPI AINM-C strategy was carried out, which consisted of the card during pregnancy, the card for postpartum, breastfeeding pamphlet, feeding guidelines, reference slip, and medicine reminder sheet.

Training

During the present quarter, 13 members of the personnel in the Department of Social Communication and Public Relations, including social workers and other categories of staff, received training in the formulation of IEC processes and the validation of materials; the established target was exceeded, reaching 130%.

3.2. Results 2: Maternal Child Programs are Better Managed

3.2.1. Support System Results

The technical assistance in Supervision-Facilitation continued in the Medical Audit, Supervision and Control Department and with the Strategic Planning Directorate, in the development of a proposal for an information system adequate to the needs and resources of the Institute.

Training

With the training of the 12 supervisors in the Medical Audit, Supervision and Control Department, the target of services units and supervisors trained in the logistics of contraceptives was 100% complied with.

Limitations

In spite of a history of successes in the 10 years of family planning in the IGSS, confirming that it is a cost effective service[16], that there are official, approved norms and manuals for a good provision of care, it still has not been given official status in the internal regulations of the Institute.

This weakness, of a legal nature, has limited the provision of family planning services exclusively until 45 days postpartum, as much to the affiliates as to the beneficiaries, implying a negative impact in the indicators for service production in this first quarter of 2004.

[16] Institutional economic impact of the family planning program in the IGSS. GSD Consultants, AVSC International, 1999.

ANNEX A
INSTRUMENTO PARA MONITOREAR AVANCE EN ÁREAS DE SALUD
MSPAS

INDICADORES	FUENTE	LOGRO 2001	META 2002	LOGRO 2002	LOGRO 2003	META 2004	LOGRO ACUMULADO %	LOGRO POR TRIMESTRE				TOTAL ANUAL
								1ro	2do	3ro	4to	
Tasa de Mortalidad infantil	ENSMI	45 x 1,000 nacidos vivos	41 x 1,000 nacidos vivos*	**39 x 1,000 nacidos vivos****	**NA******	NA						
Niños menores de 6 meses con lactancia materna exclusiva	ENSMI	39.0%	50.0% en el año 2,002	**50.6%****	**NA**	NA						
Porcentaje de niño/as 12-23 meses de edad, que han recibido todas las dosis de DPT3,Polio3, BCG y Sarampión	ENSMI	60.0%	72.0%*	**62.5%****	**NA**	NA						
Cobertura de vacunación en niño/as menores de 1 año para BCG, DPT3, Polio3 y Sarampión, y de 12 a 23 meses para SPR	SIGSA (en las 8 áreas del convenio)											
BCG	SIGSA	92.2%	90.0%	**94.0%**	**92.4%**	**95.0%**	17.0%	17%	0%			17.0%
DPT3	SIGSA	91.6%	90.0%	**91.0%**	**91.1%**	**95.0%**	14.0%	14%	0%			14.0%
POLIO3	SIGSA	91.8%	90.0%	**91.0%**	**91.1%**	**95.0%**	14.0%	14%	0%			14.0%
Sarampión***	SIGSA	22.7%	90.0%	**98.0%**	**0.0%**	**95.0%**	0.0%	0	0%			0.0%
SPR	SIGSA	90.0%	90.0%	**92.0%**	**90.6%**	**95.0%**	15.0%	15%	0%			15.0%
Uso de terapia de rehidratación oral e ingesta de líquidos en niño/as menores de 5 años durante episodios de diarrea (Sales de rehidratación oral o incremento en la ingesta de líquidos)	ENSMI	59.0%	65%*	**74.4%****	**NA**	NA						
Casos de neumonía (tos y respiración rápida) en niño/as menores de 5 años tratados por proveedor de salud	ENSMI	37.0%	45%*	**64.3%****	**NA**	NA						

Area sombreada corresponde a datos de ENSMI que se obtienen quinquenalmente

*ENSMI = Encuesta Nacional de Salud Materno Infantil 98/99. SIGSA = Sistema información Gerencial en Salud. SIMNA / UE = Salud Integral de la Mujer, Niñez y Adolescencia, Unidad Ejecutora

** Basados en el informe de la ENSMI 2002

*** A partir del 2003 solo se usa SPR

**** No Aplica

***** No hay datos disponibles por reestructuracion de SIGSA

ANNEX A
INSTRUMENTO PARA MONITOREAR AVANCE EN ÁREAS DE SALUD
MSPAS

INDICADORES	FUENTE	LOGRO 2001	META 2002	LOGRO 2002	LOGRO 2003	META 2004	LOGRO ACUMULADO %	LOGRO POR TRIMESTRE				TOTAL ANUAL
								1ro	2do	3ro	4to	
Prevalencia de uso de métodos anticonceptivos (métodos modernos y tradicionales)	ENSMI	38.2%	41.0%*	**43.3%****	**NA******	NA						
APPs (incluye AQV,toda la república)	SIMNA/UE	202,116	218,286	**266,256**	**300,539**	315,566	20.2%	63,806	0	-	0	63,806
Nuevas usuarias de Planificación Familiar (incluye AQV, toda la república)	SIGSA	153,967	165,000	**213,319**	**220,282**	231,296	20.6%	47,601	0	0	0	47,601
Tasa Global de Fecundidad	ENSMI	5	4.8*	**4.4****	**NA**	NA						

ND = No datos

* Metas para año 2002, ENSMI

Área sombreada corresponde a datos de ENSMI que se obtienen quinquenalmente

ENSMI = Encuesta Nacional de Salud Materno Infantil 98/99. SIGSA = Sistema información Gerencial en Salud. SIMNA / UE = Salud Integral de la Mujer, Niñez y Adolescencia, Unidad Ejecutora

** Basados en el informe de la ENSMI 2002

**** No Aplica

Capacitaciones Resultado 5 IGSS.
Resumen de enero a marzo 2004

PF	Med	Enf	A.Enf	T.S.	Adm	Prom	Educ	Otros	H	M	Total	Meta	%
Tutorías en servicio	1	2	4	2	1				4	6	10	25	40%
IEC	**Med**	**Enf**	**A.Enf**	**T.S.**	**Adm**	**Prom**	**Educ**	**Otros**	**H**	**M**	**Total**	**Meta**	**%**
Proceso de IEC y validación de materiales				3				10	4	9	13	10	130%

AIEPI AIEPI AINM-C	Med	Enf	A.Enf	T.S	Adm	Prom	Educ	Otros	H	M	Total	Meta	%
Aplicación de la estrategia AIEPI	25	1	9	1				2	16	22	38	30	127%
Inducción en AIEPI AIMN-C	42	24	1	7	5	26	1	11	68	49	117	117	100%
Aplicación de la estrategia AIEPI AIMN-C	42	39	129	18	1	132	9	7	127	250	377	300	126%
Tutorías en servicio	9	2	3	2	15			4	15	20	35	30	117%
Total	118	66	142	28	21	158	10	24	226	341	567	477	119%
Sistemas de Apoyo	**Med**	**Enf**	**A.Enf**	**T.S.**	**Adm**	**Prom**	**Educ**	**Otros**	**H**	**M**	**Total**	**Meta**	
Uso, conocimiento y aplicación de los manuales de administración logística	12								8	4	12	15	80%

Med: Médicos Enf: Enfermeras A. Enf: Auxiliares de Enfermería TS: Trabajo Social Adm: Administrativos
Prom: Promotores Educ: Educadoras Otros: Estudiantes, bodegueros, etc H: Hombres

Appendix D

Key IEC/BCC Indicators at Baseline (BL) and Final Survey (FS)

Indicator	BL 2001	FS 2003
Coverage		
% mothers who know community health worker	63.5	68.1
% mothers visited by a community health worker last 3 months		
- Health promoter or *vigilante*	19.4	23.9
- Traditional midwife	15.5	12.6
- Auxiliary nurse	4.3	2.5
- Rural Health Technician	1.7	0.6
- Doctor	1.7	1.7
- Other	1.2	0.3
% mothers visited by community health worker last 3 months	25.0	32.5
% mothers who have listened to message on family planning on the radio in the past 3 months	8.0	36.4
% mothers who have listened to a message on child health on the radio in the past 3 months	15.0	55.1
% mothers who have listened to a message on maternal health on the radio in the past 3 months	3.2	18.6
% mothers who have attended a health group talk in the past 3 months	14.4	11.7
% mothers who have received printed material on health in the past 3 months	6.0	21.4
% mothers who report having received a health message from other sources in the past 3 months	6.3	5.0
% mothers who report having participated in another health promotion activity in the past 3 months	1.1	1.4
Knowledge		
% mothers who know each family planning method (spontaneous and prompted recall combined)		
- LAM	19.6	18.3
- Ovulation	20.4	14.2
- Rhythm	37.1	29.1
- Collar	8.6	14.4
- Pill	72.0	81.4
- IUD	32.2	37.3
- Injection	74.4	86.7
- Condom	34.2	47.3
- Female sterilization	67.5	73.3
- Male sterilization or vasectomy	45.0	37.5
- Withdrawal	11.0	14.7

- Other	5.2	2.8
% mothers (non-users) that have communicated about family planning with spouse in the past 3 months	47.9	65.4
% mothers who recognize specific danger signs		
General		
- listlessness	58.6	69.2
- can't drink or eat anything	51.7	76.7
- fever	42.3	54.2
- vomits everything	31.9	35.3
Dehydration		
- sunken eyes	34.5	32.2
- increased thirst	2.0	8.3
Pneumonia		
- rapid breathing	17.8	16.9
- difficult breathing	26.7	30.0
- chest in-drawing	3.4	2.8
Practices		
% mothers with unmet need for family planning (women who wish to postpone or avoid pregnancy and are not using contraception)	39.3	32.9
% mothers who use a family planning method	15.8	25.8
% users who have discussed family planning with another woman	47.3	38.7
% of children who have been weighed at least once in the past 6 months	40.2	45.0
% of children 0-5 months who have been weighted at least once during last 6 months	22.9	39.7
% of children 6-11 months who have been weighed at least three times during the last 6 months	44.1	30.8
% of children 12-23 months who have been weighed at least three times during the last 6 months	18.5	19.8
% of mothers who show child vaccination card	58.1	59.9
% of children who are up-to-date in vaccines	61.2	67.5
% of mothers who report practicing hygienic measures to prevent illness in their children		
- child's hand washing	42.5	36.4
- mother's hand washing	33.6	36.4
- boils or chlorinates drinking water	34.5	18.1
- breastfeeding	10.4	16.9
- complementary feeding	34.2	44.7
- keeps foods covered, "clean food"	41.1	45.0
% of mothers who report breastfeeding last child within the first hour after delivery	40.8	63.1
% of children 0-5 months exclusively breast fed	22.9	47.9

% of children 6-24 months of age breastfeeding	79.8	86.1
% of children 6-8 months of age who receive appropriate complementary feeding (cereal, vegetable/fruit and legume)	32.4	3.3
% of children 9-11 months of age who receive adequate complementary food (cereal, vegetable/fruit, legume, and animal products)	22.6	27.3
% children 0-24 months who are being bottle-fed	55.6	48.5
% children with diarrhea last two weeks that received oral rehydration salts	39.4	37.3
% of children sick with diarrhea in the last two weeks and with danger signs who were treated by competent provider (C/C, P/S, C/S, hospital or doctor)	48.6	47.0
% of children sick with ARI in the last two weeks and with danger signs who were treated by competent provider (C/C, P/S, C/S, hospital or doctor)	63.8	57.1

Equipo de Donaciòn a la Red Hospitalaria del MSPAS Guatemala

		Acta de Valija de Emergencia	Acta de Equipo de DIU	Acta de Equipo de AQV	Acta de Clinica de PF	Aspiradores de Flema
1	Hospital Amatitlan	1	1	1	1	
1	Hospital El Progreso	1	1			
1	Hospital Nacional Pedro de Betancourt, Sacatepequez	1	1	1	1	
1	Hospital Nacional de Chimaltenango	1	1	1		
1	Hospital Nacional de Escuintla	1	1			
1	Hospital de Tiquisate	1	1	1		
1	Hospital Nacional Cuilapa, Santa Rosa	1	1	1	1	
1	Hospital Nacional de Solola	1	1			
1	Hospital Nacional de Totonicapán	1	1			
1	Hospital Nacional de Quetzaltenango	1	1	1		
1	Hospital de Coatepeque	1	1	1		1
1	Hospital Nacional de Suchitepequez, Mazatenango	1	1	1	1	
1	Hospital Nacional de Retalhuleu	1	1	1	1	
1	Hospital Nacional de San Marcos	1	1			
1	Hospital Malacatan	1	1	1	1	1
1	Hospital Nacional de Huehuetenango	1	1			
1	Hospital Santa Elena, Quiche	1	1	1		
1	Hospital Joyabaj	1	1	1		
1	Hospital Uspantan	1	1	1		
1	Hospital Nebaj	1	1	1		
1	Centro de Salud Playa Grande, Ixcan	1	1			
1	Hospital Nacional Baja Verapaz	1	1	1	1	
1	Hospital Nacional Alta Verapaz	1	1		1	1
1	Hospital Fray Bartolomé de las Casas	1	1	1		
1	Hospital La Tinta	1	1	1		
1	Hospital San Benito Peten	1	1			1
1	Hospital Melchor de Mencos, Peten	1	1			1
1	Hospital Sayaxche, Peten	1	1			
1	Hospital Poptun, Peten	1	1		1	
1	Hospital Nacional de Puerto Barrios, Izabal	1	1		1	
1	Hospital Nacional de Zacapa	1	1	1		1
1	Hospital Nacional de Chiquimula	1	1	1		
1	Hospital Nacional de Jutiapa	1	1	1	1	1
1	Hospital Nacional de Jalapa	1	1		1	
		34	34	20	12	7